

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE <u>Delaware</u> b. COUNTY <u>Sussex</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Laurel</u> 46X-3			
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>Peninsula General Hospital</u>				d. STREET ADDRESS <u>103 West Eight Street</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) <u>Richard Spencer Barr</u>				4. DATE OF DEATH <u>December 14 - 1957</u>			
5. SEX <u>male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>12/9/57</u>	
9. AGE (In years last birthday) <u>56</u>		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY			
13. FATHER'S NAME <u>William S. Barr</u>				14. MOTHER'S MAIDEN NAME <u>VERA CHARKE</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.			
17. INFORMANT <u>William S. Barr</u>				Address <u>Laurel Del</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>754.1</u> DUE TO <u>Congenital Cyanotic Heart Disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Patent ductus arteriosus</u> (c) <u>Blindly ending aorta</u> <u>Inter-vertebral spinal defect; Patent foramen</u> <u>Functionally a Truncus Arteriosus</u>						INTERVAL BETWEEN ONSET AND DEATH <u>5 DAYS</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>12/9</u> 19 <u>57</u> , to <u>12/14</u> 19 <u>57</u> , that I last saw the deceased alive on <u>12/14</u> 19 <u>57</u> , and that death occurred at <u>7:15</u> M., from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Alfred C. Kolls</u> M.D.				ADDRESS (Street, city or town, state) <u>Medical Center Salisbury, Md</u>			
DATE SIGNED <u>12/14/57</u>							
PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>12/16/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>OLD Christ Ch. Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>LAUREL Del</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>H. S. Dickerson</u>				ADDRESS <u>Laurel Del.</u>			
24a. REC'D BY REGISTRAR <u>Mary J. Holloway</u>				DATE <u>18 1957</u>			

CERTIFICATE OF DEATH

BUREAU V. S.

DEC 18 1957

RECEIVED

13717

CERTIFICATE OF DEATH

Reg. Dist. No.

1372237

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury				c. LENGTH OF STAY IN TB X2 Hebron			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Pen. Gen. Hospital				e. STREET ADDRESS 1 Railroad Ave.			
3. NAME OF DECEASED (Type or print) First ERNEST Middle MC CREADY Last BENNETT				4. DATE OF DEATH Month DECEMBER Day 4 Year 19 57			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Feb. 4, 1886	
9. AGE (In years last birthday) 71 yrs.		IF UNDER 1 YEAR Months 10 Days 0		IF UNDER 24 HRS. Hours 0 Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Employee Wayne Pump Co. (Retired)				10b. KIND OF BUSINESS OR INDUSTRY (Retired)		11. BIRTHPLACE (State or foreign country) Mardela, Maryland	
12. CITIZEN OF WHAT COUNTRY? U S A							
13. FATHER'S NAME Ebenezer T. Bennett				14. MOTHER'S MAIDEN NAME Esther Virginia Phillips			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO. 216-07-6300		17. INFORMANT Address Mrs. Clive R. Bennett (Wife) Railroad Ave. Salisbury Hebron, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Pancreatitis 587.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ INTERVAL BETWEEN ONSET AND DEATH 22 days							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) _____ (County) _____ (State) _____							
21. I certify that I attended the deceased from 4-10 , 19 55 , to 12-4 , 19 57 , that I last saw the deceased alive on 12-4 , 19 57 , and that death occurred at 3 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED _____ ACTUAL SIGNATURE Earl L. Royer M.D. PHYSICIAN'S NAME (Type) Dr. Earl L. Royer Camden Ave. Salisbury, Maryland Dec. 5 /57							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Dec. 6, 1957		22c. NAME OF CEMETERY OR CREMATORY Mardela Cemetery		22d. LOCATION (City, town, or county) (State) Mardela, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE HOLLOWAY & COMPANY FUNERAL HOME - SALISBURY, MD.				24a. REC'D BY REGISTRAR DATE DEC 9 1957			
24b. REGISTRAR'S SIGNATURE Mary Holloway							

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

RECEIVED
 DEC 9 1957
 BUREAU V. E.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13718

CERTIFICATE OF DEATH

1372837

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Worcester			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Pocomoke City 2342.2			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION In route to Peninsula General Hosp.				d. STREET ADDRESS 2nd and Ceder Streets			
3. NAME OF DECEASED (Type or print) First ALMA Middle H. Last BLAINE				4. DATE OF DEATH Month December Day 21 , Year 19 57			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 11, 1887	9. AGE (In years last birthday) yrs. 70	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none		10b. KIND OF BUSINESS OR INDUSTRY ---		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME James P. Blaine				14. MOTHER'S MAIDEN NAME Mollie A. Hargis			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 216-38-9180		17. INFORMANT Address Mrs Ida Scott, Pocomoke City, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ACUTE PULMONARY EDEMA 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) ACUTE MYOCARDIAL INFARCTION DUE TO (c) HYPERTENSIVE CARDIO VASCULAR DISEASE						INTERVAL BETWEEN ONSET AND DEATH 3 HOURS UNKNOWN	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) Pocomoke City		(County) (State)	
21. I certify that I attended the deceased from 12-21 , 19 57 , to 12-21 , 19 57 , that I last saw the deceased alive on 12-21 , 19 57 , and that death occurred at 2 AM, from the causes and on the date stated above.							
ACTUAL SIGNATURE C. Stanford Hamilton M.D.				ADDRESS (Street, city or town, state) Pocomoke City, Md.			
DATE SIGNED 12/21/57							
PHYSICIAN'S NAME (Type) C. STANFORD HAMILTON							
22a. BURIAL, CREMATION, REMOVAL (Specify) burial	22b. DATE THEREOF 12-23-57	22c. NAME OF CEMETERY OR CREMATORY Presbyterian Cemetery		22d. LOCATION (City, town, or county) (State) Pocomoke City, Maryland			
23. FUNERAL DIRECTOR'S SIGNATURE Dennis Watson				ADDRESS Pocomoke, Md.		24a. REC'D BY REGISTRAR DEC 26 1957	
				24b. REGISTRAR'S SIGNATURE Mary H. Holloway			

CERTIFICATE OF DEATH

NEW YORK STATE DEPARTMENT OF HEALTH - BUREAU OF VITAL STATISTICS

BUREAU V. 1

DEC 27 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
13762
CERTIFICATE OF DEATH

13739 ✓
Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Wicomico MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Wicomico	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hebron - Rural		c. LENGTH OF STAY IN 1b 30 years	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Quantico Road		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hebron - Rural	
d. STREET ADDRESS Quantico Road		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Ollie Middle Ellen Last Burris		4. DATE OF DEATH Month December Day 13 Year 1957	
5. SEX Female	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 17, 1907
9. AGE (In years last birthday) yrs. 50		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework		10b. KIND OF BUSINESS OR INDUSTRY Home	
11. BIRTHPLACE (State or foreign country) Somerset Co., Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Edgar Jones		14. MOTHER'S MAIDEN NAME Julia White	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 219-05-3746	
17. INFORMANT Lonnie F. Burris, Hebron, Md., R.F.D.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arterial Thrombosis DUE TO Cardio-Vascular Renal Disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Hypertension DUE TO (c) Diabetes Mellitus PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 260x INTERVAL BETWEEN ONSET AND DEATH Sudden 2 years unk.			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour 9 p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Dec 11, 1955 to Dec 13, 1957 , that I last saw the deceased alive on Dec 9, 1957 , and that death occurred at 2:30A M. from the causes and on the date stated above.			
ACTUAL SIGNATURE G. Herbert Semblly M.D.		ADDRESS (Street, city or town, state) Salisbury Md DATE SIGNED 12/14/57	
PHYSICIAN'S NAME (Type) G. Herbert Semblly			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Dec. 15, 1957	
22c. NAME OF CEMETERY OR CREMATORY Mt. Zion Church Cemetery		22d. LOCATION (City, town, or county) (State) Quantico, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE J.J. Frampton and Son, Federalburg, Maryland		ADDRESS	
24a. REC'D BY REGISTRAR DEC 18 1957		24b. REGISTRAR'S SIGNATURE Mary H. Hollaway	

BUREAU V. S.

DEC 18 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13719 CERTIFICATE OF DEATH

Reg. Dist. No. 372

13730

1. PLACE OF DEATH a. COUNTY WICOMICO MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY WICOMICO			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SALISBURY				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SALISBURY 12			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 1 YEAR				d. STREET ADDRESS 1			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last ARCHIE CORNISH				4. DATE OF DEATH Month Day Year 12 2 1957			
5. SEX MALE		6. COLOR OR RACE COLORED		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH ??	
9. AGE (In years last birthday) 64 YEARS		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) BLIND				10b. KIND OF BUSINESS OR INDUSTRY NONE		11. BIRTHPLACE (State or foreign country) MARYLAND	
12. CITIZEN OF WHAT COUNTRY? U S A.							
13. FATHER'S NAME DANIEL CORNISH				14. MOTHER'S MAIDEN NAME ELIZA BYRD			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT Address DORTHY CORNISH PRINCESS ANNE MD. RED			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 334x DUE TO Cerebrovascular Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Atherosclerosis DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH 2 months Indefinite	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 2 Oct , 19 57 , to 2 Dec , 19 57 , that I last saw the deceased alive on 2 Dec 1957 , and that death occurred at 10 P. M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 6524 main ST Salisbury, Md DATE SIGNED 6 Dec 57 ACTUAL SIGNATURE E. A. Purnell M.D. PHYSICIAN'S NAME (Type) E. A. Purnell, M.D. Salisbury, Md							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12/7/57		22c. NAME OF CEMETERY OR CREMATORY Wagon		22d. LOCATION (City, town, or county) (State) Back Road Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE William H. James Jr. Princess Anne, Md				24a. REC'D BY REGISTRAR DATE 12-7-57		24b. REGISTRAR'S SIGNATURE Mary W. Holloway	

STATE OF NEW YORK
DEPARTMENT OF HEALTH - BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

BUREAU V. S.

DEC 10 1957

RECEIVED

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
13720 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

13731
22✓

1 PLACE OF DEATH a. COUNTY Wicomico MARYLAND		2 USUAL RESIDENCE (Where deceased lived) II Institution: Residence before admission a. STATE Maryland b. COUNTY Wicomico	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Peninsula General Hospital		f. STREET ADDRESS 116 Fooks St.	
3. NAME OF DECEASED (Type or print) First Middle Last John Simpson Coulter 3rd		4. DATE OF DEATH Month Day Year 12- 8- 19 57	
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> WIDOWED <input type="checkbox"/>	8. DATE OF BIRTH Sent. 2, 1957
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) infant		10b. KIND OF BUSINESS OR INDUSTRY None	
11. BIRTHPLACE (State or foreign country) Maryland-Salisbury Hosp.		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME John Simpson Coulter Jr		14. MOTHER'S MAIDEN NAME Irene Beatrice Wilkerson	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. Mr. John S. Coulter (Father) 116 Fook St. Salisbury, Maryland	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute laryngo-tracheo-bronchitis DUE TO Conditions, if any, which gave rise to immediate cause (b) _____ (c), stating the underlying cause lost. (c) _____ DUE TO			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH Sudden			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held on <u>Autopsy</u> <input checked="" type="checkbox"/> , <u>Inspection</u> <input checked="" type="checkbox"/> , <u>Inquiry</u> <input checked="" type="checkbox"/> , and in my opinion death resulted from. <u>Natural causes</u> <input checked="" type="checkbox"/> , <u>Accident</u> <input type="checkbox"/> , <u>Suicide</u> <input type="checkbox"/> , <u>Homicide</u> <input type="checkbox"/> , <u>Undetermined manner</u> <input type="checkbox"/>			
ACTUAL SIGNATURE Earl L. Royer		DATE SIGNED 12-10-57	
EXAMINER'S NAME (Type) Earl L. Royer, M.D.		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Dec. 11, 1957	22c. NAME OF CEMETERY OR CREMATORY Wicomico Memorial Park	22d. LOCATION (City, town, or county) (State) Salisbury, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE HOLLOWAY & COMPANY FUNERAL HOME - SALISBURY, MD.		24a. REC'D BY REG. STRAR DEC 11 1957	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

2032252XV4

RECEIVED
JAN 10 1964
U. S. AIR FORCE

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13721

CERTIFICATE OF DEATH

Reg. Dist. No.

(13732)
13732

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>WICOMICO</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>				c. LENGTH OF STAY IN 1b <u>1 WK</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Penninsula General Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>BRIAN</u> First <u>DOUGLAS</u> Middle <u>CULVER</u> Last				4. DATE OF DEATH Month <u>December</u> Day <u>14</u> Year <u>1957</u>			
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>1/3/1955</u>	
9. AGE (In years, last birthday) <u>2</u> yrs.		10. KIND OF BUSINESS OR INDUSTRY <u>Baby</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>ROBERT L. CULVER, SR.</u>				14. MOTHER'S MAIDEN NAME <u>Ruth CHAFFEY</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, unknown) <u>NO</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO <u>NONE</u>			
17. INFORMANT <u>ROBERT L. CULVER, Sr.</u>				Address <u>SAME.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Hepatic Failure</u> <u>U12X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Hepatitis, acute - ? Serum infectious</u> DUE TO (c) <u>2 weeks</u>							INTERVAL BETWEEN ONSET AND DEATH <u>2 weeks</u>
PART II - OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Leukemia, acute lymphocytic</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>Dec 7</u> 19 <u>57</u> , to <u>Dec 14</u> 19 <u>57</u> , that I last saw the deceased alive on <u>Dec 14</u> 19 <u>57</u> , and that death occurred at <u>5</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>R. W. Saunderson Jr.</u>				ADDRESS (Street, city or town, state) <u>976 Division St. Salisbury, Md.</u>			
DATE SIGNED <u>12/14/57</u>				PHYSICIAN'S NAME (Type) <u>ROBERT W. SAUNDERSON JR. Salisbury Md</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>BURIAL</u>		<u>12/17/1957</u>		<u>PARSONS CEMETERY</u>		<u>SALISBURY, MARYLAND</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Will Johnson</u>				ADDRESS <u>Salisbury, Md.</u>		24a. REC'D BY REGISTRAR <u>Mary W. Holloway</u>	
24b. REGISTRAR'S SIGNATURE <u>Norman F. Baker</u>				DATE <u>12-10-57</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with page 3 and be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

ROMANOV V. S.



FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

13733

13763

1. PLACE OF DEATH a. COUNTY Wicomico		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland b. COUNTY Wicomico	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hebron		c. LENGTH OF STAY IN 1b 3 mo.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) RFD # 1		d. STREET ADDRESS RFD # 1	
3. NAME OF DECEASED (Type or print) First Middle Last Mamie Xx Curtis		4. DATE OF DEATH Month Day Year 12-12-1957	
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 11, 1888
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY home	9. AGE (In years last birthday) 69 yrs
13. FATHER'S NAME Unknown		11. BIRTHPLACE (State or foreign country) Wash. D.C.	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		12. CITIZEN OF WHAT COUNTRY? U S A	
16. SOCIAL SECURITY NO ?		14. MOTHER'S MAIDEN NAME Jeannie Newcomb	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)		17. INFORMANT Address Husband: Elmer Curtis Hebron, Md.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)		
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Earl L. Royer		DATE SIGNED 12-12-57	
EXAMINER'S NAME (Type) Earl L. Royer, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, OR REMOVAL (Specify) cremation	22b. DATE THEREOF 12-13-57	22c. NAME OF CEMETERY OR CREMATORY Loudon Park	22d. LOCATION (City, town or county) (State) Baltimore, Md.
23. FLUNERAL DIRECTOR'S SIGNATURE Levin R. Wilson		24. REC'D BY REGISTRAR 1957	
25. ADDRESS Princess Anne, Md.		24b. REGISTRAR'S SIGNATURE Mary J. Hollingsworth	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 shall be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

27 1957

RECEIVED

13722 CERTIFICATE OF DEATH

13734

Reg. Dist. No. 331

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> ^{MD} b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u> c. LENGTH OF STAY in 1b <u>Life</u> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		2. USUAL RESIDENCE (Where deceased lived If institution; Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Wicomico</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u> d. STREET ADDRESS <u>512 Tanager St.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Clifford S. Doshill</u> First Middle Last 4. DATE OF DEATH <u>12-1-1957</u> Month Day Year		5. SEX <u>M</u> 6. COLOR OR RACE <u>C</u> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH <u>1894</u> 9. AGE (In years last birthday) <u>63</u> yrs IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Labor</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>none</u> 11. BIRTHPLACE (State or foreign country) <u>District of Columbia</u> 12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>Unknown</u> 14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>?</u> 17. INFORMANT <u>Lucie Doshill - 512 Tanager St.</u> Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of Stomach</u> <u>151X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>151X</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH <u>yr -</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>7-22</u> , 1957, to <u>12-1</u> , 1957, that I last saw the deceased alive on <u>11-30</u> , 1957, and that death occurred at <u>Salisbury, Md.</u> from the causes and on the date stated above.			
SIGNATURE <u>Earl L Royer</u> M.D.		ADDRESS (Street, city or town, state) <u>407 Camden Ave</u> DATE SIGNED <u>12-4-57</u>	
PHYSICIAN'S NAME (Type) <u>Earl L Royer</u>		<u>Salisbury Md</u>	
22a. BURIAL, CREMATION, or other disposal (Specify)	22b. DATE THEREOF <u>12-6-57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Green Hill</u>	22d. LOCATION (City, town, or county) (State) <u>Salisbury Md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>13. J. J. J. J.</u> ADDRESS		24a. REC'D BY REGISTRAR <u>DEC 4</u>	24b. REGISTRAR'S SIGNATURE <u>Mary Halloway</u>

RECEIVED

DEC 9 1967

BUREAU V. S.

13735

13764

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mardela		c. LENGTH OF STAY IN 1b 25 years	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mardela		d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION	
d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Georgia Middle Anna Last Dashiell		4. DATE OF DEATH Month December Day 17 Year 1957	
5. SEX Female	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH February 28, 1893
9. AGE (In years last birthday) 64 yrs.		10. IF UNDER 1 YEAR Months 64 Days 0 Hours 0 Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework		10b. KIND OF BUSINESS OR INDUSTRY Home	
11. BIRTHPLACE (State or foreign country) Accomack, Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Thomas Wise		14. MOTHER'S MAIDEN NAME Esther (maiden name unknown)	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No		16. SOCIAL SECURITY NO (If yes, give war or dates of service) 213-18-4148	
17. INFORMANT Ira A. Dashiell, Mardela, Maryland		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac failure DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) arteriovenous aneurysm external carotid right DUE TO (c) unknown PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Acute Glomerulonephritis INTERVAL BETWEEN ONSET AND DEATH 1 year			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 7/1 , 19 57 , to death , 19 57 , that I last saw the deceased alive on Dec 15 , 19 57 , and that death occurred at 2:30 A.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 100 Grove Delmar, Del 12415 DATE SIGNED ACTUAL SIGNATURE Ernest M Larmore M.D. 100 Grove Delmar, Del 12415 PHYSICIAN'S NAME (Type) ERNEST LARMORE 100 GROVE DELMAR, DEL			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Dec. 22, 1957	
22c. NAME OF CEMETERY OR CREMATORY John Wesley Cemetery		22d. LOCATION (City, town, or county) (State) Mardela, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE J.J. Frampton and Son, Federalburg, Maryland		24a. REC'D BY REGISTRAR DEC 23 1957	
24b. REGISTRAR'S SIGNATURE Horn Holloway			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

VS A15 (4
15M 9/55

25

BUREAU V. S.

DEC 23

1901

13765

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Fruitland</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Isabella Street</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Isabella Street</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Hannah</u> First Middle Last <u>Deal</u>				4. DATE OF DEATH Month <u>12</u> Day <u>10</u> Year <u>1957</u>			
5 SEX <u>Female</u>		6 COLOR OR RACE <u>Colored</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Unknown</u>	
9. AGE (In years last birthday) <u>93</u> yrs.		IF UNDER 1 YEAR		IF UNDER 24 HRS			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Domestic</u>		10b. KIND OF BUSINESS OR INDUSTRY		11 BIRTHPLACE (State or foreign country) <u>Maryland</u>		12 CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Unknown</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Virgil Deal Fruitland Md.</u> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebrovascular disease</u> DUE TO <u>Arteriosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Definite</u> DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH <u>4 mo</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>10 Sept</u> 19 <u>57</u> , to <u>10 Dec</u> 19 <u>57</u> , that I last saw the deceased alive on <u>10 Dec</u> 19 <u>57</u> , and that death occurred at <u>7:30</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>652 W main St., Salisbury, Maryland</u> DATE SIGNED <u>E. A. Purnell</u>							
ACTUAL SIGNATURE <u>E. A. Purnell</u>				M.D. <u>Salisbury, Maryland</u>			
PHYSICIAN'S NAME (Type) <u>E. A. Purnell</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>12 13 57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Mt. Calvary</u>		22d. LOCATION (City, town, or county) (State) <u>Fruitland Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Christopher Stewart</u>				24. REC'D BY REGISTRAR <u>Salisbury Md.</u>		25. REGISTRAR'S SIGNATURE <u>Mary Hollaway</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

DEC 13 1957

RECEIVED

13723

CERTIFICATE OF DEATH

Reg. Dist. No.

13736
332

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Pen. Gen. Hospital		d. STREET ADDRESS 44 Cherry Way	
3. NAME OF DECEASED (Type or print) First COLLEY Middle DILL Last DILL		4. DATE OF DEATH Month DECEMBER Day 26th Year 19 57	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 17, 1903
9. AGE (In years last birthday) 55 yrs.		IF UNDER 1 YEAR Months 3 Days 9	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer Employee		10b. KIND OF BUSINESS OR INDUSTRY Plumbing	
11. BIRTHPLACE (State or foreign country) Delaware		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME Alexander Dill		14. MOTHER'S MAIDEN NAME Priscilla -	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Unk (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Mrs. Norma G. Scott (Daughter)		Address #44 Cherry Way Salisbury, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 404.1 DUE TO Coronary failure Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 6/7 19 57 , to 12/26 , 19 57 , that I last saw the deceased alive on 12/26 , 19 57 , and that death occurred at 7:30 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE Dr. Andrew C. Mitchell M.D.		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
PHYSICIAN'S NAME (Type) Dr. Andrew C. Mitchell		Maryland Ave. Salisbury, Md. Dec. 127 57	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Dec. 29, 1957	22c. NAME OF CEMETERY OR CREMATORY Odd Fellow Cemetery	22d. LOCATION (City, town, or county) (State) Canden, Delaware
23. FUNERAL DIRECTOR'S SIGNATURE TORBERT FUNERAL SERVICE - DOVER, DELAWARE		24a. REC'D BY REGISTRAR DATE 12-30-57	
24b. REGISTRAR'S SIGNATURE Mary Holloway			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

EC 80 1957

BUREAU V. R.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13724

CERTIFICATE OF DEATH

Reg. Dist. No. 33832

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE Maryland b. COUNTY Wicomico	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 12 Salisbury	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 306 Martin St		d. STREET ADDRESS 306 Martin St.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First IDA Middle ISABELLE Last DILL		4. DATE OF DEATH Month DECEMBER Day 30th Year 19 57	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH January 14, 1877
9. AGE (In years lost birthday) 80 yrs		10. IF UNDER 1 YEAR 11 Months 16 Days	11. IF UNDER 24 HRS. Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Work		10b. KIND OF BUSINESS OR INDUSTRY None	11. BIRTHPLACE (State or foreign country) Bishopville, Maryland
12. CITIZEN OF WHAT COUNTRY? U S A			
13. FATHER'S NAME James Campbell		14. MOTHER'S MAIDEN NAME Sallie Hudson	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO	
17. INFORMANT Mrs. Ida Mae Swinehart (Daughter) Address 306 Martin St. Salisbury, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I DEATH WAS CAUSED BY— IMMEDIATE CAUSE (a) congestive heart failure 4 d. d. d. DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) degenerative heart disease DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH 11 d. 5 yr.
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> of work Nat while <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 12/15 , 19 57 , to 12/30 , 19 57 , that I last saw the deceased alive on 12/30 , 19 57 , and that death occurred at 10:00 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED Dr. Earl Beardsley M.D. Dec 30/57			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Jan. 2, 1957	22c. NAME OF CEMETERY OR CREMATORY Parsons Cemetery
22d. LOCATION (City, town, or county) Salisbury, Maryland		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE HOLLOWAY & COMPANY FUNERAL HOME ADDRESS SALISBURY, MD.		24a. REC'D BY REGISTRAR Jan 3 1958	24b. REGISTRAR'S SIGNATURE Mary Holloway

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. 3

JAN 3 1959

RECEIVED

13725

CERTIFICATE OF DEATH

Reg. Dist. No.

13734
33 ✓

1. PLACE OF DEATH a. COUNTY <u>WICOMICO</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>SOMERSET</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SALISBURY</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RURAL Pocomoke City</u>	
c. LENGTH OF STAY IN 1b <u>6 WEEKS</u>		d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>SPRINGHILL SANATORIUM</u>	
d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>SALLIE</u> Middle <u>C.</u> Last <u>DRYDEN</u>		4. DATE OF DEATH Month <u>DEC.</u> Day <u>26</u> Year <u>1957</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>FEB. 14-1872</u>
9. AGE (In years last birthday) <u>85</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>	
11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>JOSEPH W. TILGHMAN</u>		14. MOTHER'S MAIDEN NAME <u>CATHERINE CLUFF</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>—</u>		16. SOCIAL SECURITY NO <u>NONE</u>	
17. INFORMANT <u>CLIFFORD M. DRYDEN, Pocomoke</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis</u> DUE TO <u>Cerebral Arteriosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) <u>—</u> (c) <u>—</u> INTERVAL BETWEEN ONSET AND DEATH <u>2 months</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Oct</u> , 19 <u>57</u> , to <u>Dec. 20</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>Dec. 20</u> , 19 <u>57</u> , and that death occurred at <u>Salisbury, Md.</u> , from the causes on <u>Dec. 27</u> , 19 <u>57</u> .			
ACTUAL SIGNATURE <u>Harold J. Gilmore</u> M.D.		DATE SIGNED <u>Dec. 27, 1957</u>	
PHYSICIAN'S NAME (Type) <u>Harold J. Gilmore</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>12/28/57</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>PRESBYTERIAN</u>		22d. LOCATION (City, town, or county) (State) <u>REHOBOTH MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Henry S. Watson</u>		24a. REC'D BY REGISTRAR <u>DEC 28 1957</u>	
ADDRESS <u>Pocomoke Md.</u>		24b. REGISTRAR'S SIGNATURE <u>Mary Holloway</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

DEC 7 1957

BUREAU V. S.

13766 CERTIFICATE OF DEATH

13740

335

Reg. Dist. No.

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY Wicomico		MARYLAND		STATE Maryland		COUNTY Wicomico	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Sharptown		LENGTH OF STAY (In this place) 20 yrs		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Sharptown			
HOSPITAL OR INSTITUTION OR STREET ADDRESS Railway Street				STREET ADDRESS (If rural give location) Railway Street			
3. NAME OF DECEASED (Type or Print) Pearl Eaton				4. DATE OF DEATH Dec. 23 1957			
5. SEX Female		6. COLOR OR RACE White		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married		8. DATE OF BIRTH Sept. 9, 1878	
				9. AGE last birthday 79 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) At Home				10b. KIND OF BUSINESS OR INDUSTRY Home		11. BIRTHPLACE (State or foreign country) North Carolina	
12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME Unknown				14. MOTHER'S MAIDEN NAME Unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) No				16. SOCIAL SECURITY NO. None		17. INFORMANT & ADDRESS Benjamin Eaton, Sharptown, Md.	
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) Cerebral Hemorrhage							
ANTECEDENT CAUSE(S) DUE TO (B) Hypertension + Arteriosclerosis							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C) Chronic Vascular Disease							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION					
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, of INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21e. INJURY OCCURRED		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 12/23 1957 to 12/23 1957 , that I last saw the deceased alive on 12/23 1957 , and that death occurred at 6 AM , from the causes and on the date stated above.							
SIGNATURE Charles M. May				ADDRESS (Street, city, town, state)		DATE SIGNED	
M.D. Laurel Hill							
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF 12-26-57		NAME OF CEMETERY OR CREMATORY Firemans		LOCATION (City, town, or county) (State) Sharptown, Md.	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE Mary C. Owens		25. FUNERAL DIRECTOR'S SIGNATURE Charles W. Gandy, Sharptown, Md.		ADDRESS	
DATE DEC 30 1957							

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The body copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

BUREAU V. S.

1957

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RECEIVED

Thank you for the

13726

CERTIFICATE OF DEATH

13741

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Somerset</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Princess Anne</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Peninsula General Hospital</u>				d. STREET ADDRESS <u>Princess Anne Md.</u>			
3. NAME OF DECEASED (Type or print) <u>Valentine E. Eby</u>				4. DATE OF DEATH <u>December 31 - 1957</u>			
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb 14 1886</u>	9. AGE (In years last birthday) <u>71</u> yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Farmer</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Iowa</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>				13. FATHER'S NAME <u>Samuel E. Eby</u>			
14. MOTHER'S MAIDEN NAME <u>Harriett Chapin</u>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u> (If yes, give war or dates of service) <u>World War 1 1917-1918</u>			
16. SOCIAL SECURITY NO. <u>217-30-8043</u>				17. INFORMANT <u>Mrs. Robert Street Princess Anne</u> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Generalized abdominal carcinomatosis</u> DUE TO (b) <u>Carcinoma of fundus of Uterus</u> DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.						INTERVAL BETWEEN ONSET AND DEATH <u>3 1/2 yrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) _____ (County) _____ (State) _____							
21. I certify that I attended the deceased from <u>12-25-1957</u> to <u>12-31-1957</u> that I last saw the deceased alive on <u>12-31-57</u> , 19____, and that death occurred at <u>11:10 AM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>William H. Fisher Jr.</u> M.D.				ADDRESS (Street, city or town, state) <u>Salisbury Md.</u>			
DATE SIGNED _____							
PHYSICIAN'S NAME (Type) _____							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Jan 3 1958</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Episcopal Cemetery</u>		22d. LOCATION (City, town, or county) <u>Princess Anne Md.</u> (State) _____	
23. FUNERAL DIRECTOR'S SIGNATURE <u>James Thomas Princess Anne Md.</u>				24a. REC'D BY REGISTRAR <u>1958</u>		24b. REGISTRAR'S SIGNATURE <u>Mary H. H. H. H.</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3, should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13767

CERTIFICATE OF DEATH

13742

Reg. Dist. No.

1 PLACE OF DEATH a COUNTY Wicomico MARYLAND		2 USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a STATE Maryland b COUNTY Wicomico	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION R.D.# 3 (Zion Rd)		d STREET ADDRESS R.D.# 3 (Zion Rd)	
3 NAME OF DECEASED (Type or print) First EDITH Middle MATILDA Last FARLOW		4. DATE OF DEATH Month DECEMBER Day 21st Year 1957	
5 SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 5, 1885
9. AGE (In years last birthday) 72 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months 5 Days 16 Hours Min. 	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Work at Home		10b. KIND OF BUSINESS OR INDUSTRY None	
11. BIRTHPLACE (State or foreign country) Wicomico County Maryland		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME John Handy Livingston		14. MOTHER'S MAIDEN NAME Gertrude Matilda Ruzak	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) 		16. SOCIAL SECURITY NO 	
17. INFORMANT Mr. George W. Farlow (Husband)		Address R.D.# 3 Zion Rd. Salisbury, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cirrhosis of Liver DUE TO 10-10 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) 			INTERVAL BETWEEN ONSET AND DEATH 2 yrs
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Congestive Heart Failure			19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. 	20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 1946 to 12-21-57 , that I last saw the deceased alive on 12-21-57 , and that death occurred at 7:30 A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Dr. Lee Lawry		ADDRESS (Street, city or town, state) Fruitland, Md. DATE SIGNED Dec. 21/1957	
PHYSICIAN'S NAME (Type) Dr. Lee Lawry		Fruitland, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Dec. 23, 1957	22c. NAME OF CEMETERY OR CREMATORY Parsons Cemetery	22d. LOCATION (City, town, or county) (State) Salisbury, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE HOLLOWAY & COMPANY FUNERAL HOME - SALISBURY, MD.		24. RECEIVED BY REGISTRAR DEC 27 1957 REGISTRAR'S SIGNATURE Mary K. Holloway	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

DEC 27 1957

BUREAU V. C.

13727

CERTIFICATE OF DEATH

Reg. Dist. No.

1 PLACE OF DEATH a. COUNTY Wicomico b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury, Maryland c. LENGTH OF STAY IN 1b 2yrs3mo.16days d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Deer's Head State Hospital		2 USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland b. COUNTY Dorchester c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge, Maryland d. STREET ADDRESS Academy Street e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Ethel Middle Ball Last Fountain		4. DATE OF DEATH Month Dec. Day 15 Year 57	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 2, 1877
9. AGE (In years last birthday) 80		IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min 0	IF UNDER 24 HRS Months 0 Days 0 Hours 0 Min 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) unk		10b. KIND OF BUSINESS OR INDUSTRY unk	11. BIRTHPLACE (State or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME John Anderton Fountain	
14. MOTHER'S MAIDEN NAME Wilhelmina Mills		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no or unknown) unk (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO. unk		17. INFORMANT Hospital Records Address Salisbury, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hypertensive arterioslerotic cardiovascular disease 445A DUE TO Acute heart failure Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) 1 day DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH yrs.			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from Aug. 8, 19 55, to Dec. 15, 19 57, that I last saw the deceased alive on Dec. 15, 19 57, and that death occurred at 9:09 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Salisbury, Maryland DATE SIGNED 12/15/57			
ACTUAL SIGNATURE Gerhard Kosmahly M.D.		PHYSICIAN'S NAME (Type) Gerhard Kosmahly, M.D.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 12/17/57	22c. NAME OF CEMETERY OR CREMATORY Dorchester Mem. Park	22d. LOCATION (City, town, or county) (State) Cambridge md
23. FUNERAL DIRECTOR'S SIGNATURE W. LeCroy ADDRESS Cambridge, Md		24a. REC'D BY REGISTRAR DATE 12/17/57	24b. REGISTRAR'S SIGNATURE John T. ...

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

WILLIAM A. B.

DEC 1917

RECEIVED

13728

CERTIFICATE OF DEATH

Reg. Dist. No.

33r

1 PLACE OF DEATH a. COUNTY Wicomico				2 USUAL RESIDENCE [Where deceased lived If institution, Residence before admission] a. STATE MARYLAND				b. COUNTY Worcester			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SALISBURY				c. LENGTH OF STAY IN 1b 1 Day				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) OCEAN CITY			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION PENINSULA GENERAL HOSPITAL				d. STREET ADDRESS				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last ELIJAH THOMAS GARLICK				4. DATE OF DEATH Month Day Year DECEMBER 2 1957							
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH JAN. 19, 1880		9. AGE (In years last birthday) 77 yrs		IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) PUBLISHER				10b. KIND OF BUSINESS OR INDUSTRY DAILY PAPER				11. BIRTHPLACE (State or foreign country) OLDHAM, ENGLAND			
12. CITIZEN OF WHAT COUNTRY? USA.				13. FATHER'S NAME JAMES WILLIAM GARLICK				14. MOTHER'S MAIDEN NAME UNKNOWN			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO				16. SOCIAL SECURITY NO. NO				17. INFORMANT MR. S. WILLIAM GARLICK, OCEAN CITY, MD			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 450.0 DUE TO (b) Myocardial infarction DUE TO (c) Coronary atherosclerosis								INTERVAL BETWEEN ONSET AND DEATH 48 hrs			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town)				20g. (County)				20h. (State)			
21. I certify that I attended the deceased from 12:15, 1957 to 12:15, 1957 that I last saw the deceased alive on 12:15, 1957, and that death occurred at 11:55 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED H. P. Briele M.D. Medical Center 12-3-57											
ACTUAL SIGNATURE				PHYSICIAN'S NAME (Type) H. P. Briele							
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL				22b. DATE THEREOF 12/6/57				22c. NAME OF CEMETERY OR CREMATORY EVERGREEN			
22d. LOCATION (City, town, or county) BERLIN				22e. (State) MD							
23. FUNERAL DIRECTOR'S SIGNATURE Anna A. Burby				ADDRESS Berlin Md				24a. REC'D BY REGISTRAR DATE 12-5-1957			
24b. REGISTRAR'S SIGNATURE Mary W. Holloway											

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

U. S. A.

1957

DEAL

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

Items 8 & 9, Film G225, 2/14/58 fcy

CERTIFICATE OF DEATH

13746

332

Reg. Dist. No.

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <i>Wicomico</i>		STATE <i>MD</i> COUNTY <i>Wicomico</i>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <i>Dalisbury MD</i>		STREET ADDRESS (If rural give location)	
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <i>Dalisbury</i>		LENGTH OF STAY (in this place) <i>70</i>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <i>Dalisbury MD</i>		STREET ADDRESS (If rural give location)	
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
3. NAME OF DECEASED (First) (Middle) (Last) <i>Jannie L Gandy</i>				4. DATE OF DEATH (Month) (Day) (Year) <i>12 29 1957</i>			
5. SEX <i>F</i>	6. COLOR OR RACE <i>C</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <i>Married</i>	8. DATE OF BIRTH <i>2-27-1903?</i>	9. AGE last birthday <i>58?</i> yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Domestic</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>none</i>		11. BIRTHPLACE (State or foreign country) <i>S.C.</i>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <i>Paul Hogood</i>				14. MOTHER'S MAIDEN NAME <i>Howard Gandy</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO. <i>215-4-3382</i>		17. INFORMANT & ADDRESS <i>Howard Gandy</i>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
IMMEDIATE CAUSE (A) <i>Uremia</i>				INTERVAL BETWEEN ONSET AND DEATH <i>10 days</i>			
ANTECEDENT CAUSE(S) DUE TO (B) <i>subacute glomerulonephritis</i>				<i>11 months</i>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <i>Hypertension, hypertensive heart disease</i>				<i>2</i>			
19a. DATE OF OPERATION				19b. MAJOR FINDINGS OF OPERATION			
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <input type="checkbox"/> While at work <input type="checkbox"/> Not while at work		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <i>Sept 29, 1957</i> to <i>Dec 29, 1957</i> that I last saw the deceased alive on <i>Dec 29, 1957</i> and that death occurred at <i>10:20 P.M.</i> from the causes and on the date stated above.							
SIGNATURE <i>J. V. S. Miller</i> M.D.				ADDRESS (Street, city, town, state) <i>Delmar, MD.</i> DATE SIGNED <i>12-30-57</i>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		DATE THEREOF <i>1-2-58</i>		NAME OF CEMETERY OR CREMATORY <i>Blue Hill Cem</i>		LOCATION (City, town, or county) (State) <i>Parsonstown MD</i>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <i>Mary Hollaway</i>		25. FUNERAL DIRECTOR'S SIGNATURE <i>Brooks & Black</i>			
DATE							

JAN 1958



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13768 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13745
33 ✓

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND		7 USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Quantico</u>		c. LENGTH OF STAY IN 1b <u>life</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>XO R F D # 1 Quantico</u>	
3 NAME OF DECEASED (Type or print) <u>Georgia Emily Gates</u>		d. STREET ADDRESS <u>R F D # 1</u>	
5. SEX <u>F</u>		4 DATE OF DEATH Month <u>12</u> Day <u>19</u> Year <u>1957</u>	
6 COLOR OR RACE <u>C</u>		8 DATE OF BIRTH <u>68(11-12-1889) 68</u>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <u>WIDOWED</u> <input checked="" type="checkbox"/> <u>DIVORCED</u> <input type="checkbox"/>		9 AGE (In years last birthday) <u>68</u>	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		11 BIRTHPLACE (State or foreign country) <u>Maryland</u>	
10b KIND OF BUSINESS OR INDUSTRY <u>Home</u>		12. CITIZEN OF WHAT COUNTRY? <u>U S A</u>	
13 FATHER'S NAME <u>George Price</u>		14. MOTHER'S MAIDEN NAME <u>Minnie Jones</u>	
15 WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16 SOCIAL SECURITY NO <u>219-05-3636</u>	
17. INFORMANT <u>Mrs. Emma Dorman, Quantico, Md.</u>		Address	
18 CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> <u>450.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>Arterio-sclerotic cardio-vascular disease</u> (c) <u>Years</u> [If yes, give year or dates of service]		INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of form 18)	
20c TIME OF INJURY Month, Day, Year Hour <u>a. m.</u> <u>19</u> p. m.		20d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Earl L. Royer</u>		DATE SIGNED <u>12-20-57</u>	
EXAMINER'S NAME (Type) <u>Earl L. Royer, M.D.</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a BURIAL, CREMATION, REMOVAL (Specify) <u>Burial 12-22-57</u>		22b DATE THEREOF	
22c NAME OF CEMETERY OR CREMATORY <u>Head Creek Cemetery</u>		22d LOCATION (City, town, or county) (State) <u>Quantico, R F D # 1, Md.</u>	
23 FUNERAL DIRECTOR'S SIGNATURE <u>J. F. Stewart</u>		24a REC'D BY REGISTRAR <u>DATE</u>	
24b REGISTRAR'S SIGNATURE <u>Mary H. [Signature]</u>		24c REGISTRAR'S SIGNATURE	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

DEC 27 1957

BUREAU V. 1

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The body copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

13730 CERTIFICATE OF DEATH

13747

937

Reg. Dist. No.

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY Wicomico		MARYLAND		STATE Maryland		COUNTY Wicomico	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Salisbury		LENGTH OF STAY (in this place) 2 1/2 yrs		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Rural-Salisbury			
HOSPITAL OR INSTITUTION OR STREET ADDRESS Pine Bluff State Hospital				STREET ADDRESS (If rural give location) R.F.D. # 2			
3. NAME OF DECEASED (Type or Print) Emma Elizabeth Haddock				4. DATE OF DEATH (Month) Dec. (Day) 8 (Year) 19 57			
5. SEX F	6. COLOR OR RACE W	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) W	8. DATE OF BIRTH Feb. 28, 1884	9. AGE last birthday 73 yrs.	IF UNDER 1 YEAR Months _____ Days _____		IF UNDER 24 HRS. Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY -----		11. BIRTHPLACE (State or foreign country) Delaware		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Benjamin Ellingsworth				14. MOTHER'S MAIDEN NAME Martha Tumie			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) no		16. SOCIAL SECURITY NO. none		17. INFORMANT & ADDRESS Mr. William A. Haddock (Son) Records of Pine Bluff State Hosp. R.D. #2			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
IMMEDIATE CAUSE (A) Pulmonary tuberculosis				INTERVAL BETWEEN ONSET AND DEATH 3 yrs.			
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE							
STATING UNDERLYING CAUSE LAST. DUE TO							
(C)							
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from Jul. 1 , 19 57 , to Dec. 8 , 19 57 , that I last saw the deceased alive on Dec. 7 , 19 57 , and that death occurred at 7:30 P.M. from the causes and on the date stated above 12/8/57							
SIGNATURE <i>E. P. Ritchings</i>				ADDRESS (Street, city, town, state) 12/8/57			
E. P. Ritchings, M.D.				M.D. Pine Bluff State Hospital, Salisbury, Md.			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF Dec. 11, 1957		NAME OF CEMETERY OR CREMATORY Line Church Cemetery		LOCATION (City, town, or county) (State) R.D. # Pittsville, Maryland	
24. REC'D BY REGISTRAR DATE DEC 11 1957		REGISTRAR'S SIGNATURE <i>Mary J. Holloway</i>		25. FUNERAL DIRECTOR'S SIGNATURE HOLLOWAY & COMPANY FUNERAL HOME -SALISBURY, MD.			

370

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 1 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 2 and 3 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
 15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13731

CERTIFICATE OF DEATH

13748

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury				c. LENGTH OF STAY IN 1b 2 months			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Deer's Head State Hospital				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis			
d. STREET ADDRESS 55 Calvert Street				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Helen Middle Hayes Last Dec.				4. DATE OF DEATH Month 3 Day 1957			
5. SEX Female		6. COLOR OR RACE Col.		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 1/17/1914	
9. AGE (In years last birthday) 43 yrs.		IF UNDER 1 YEAR Months 4 Days 4 Hours 4 Min		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) -				10b. KIND OF BUSINESS OR INDUSTRY -		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME Frank Abrams				14. MOTHER'S MAIDEN NAME Anna Francis			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) Unk.		16. SOCIAL SECURITY NO. Unk.		17. INFORMANT Hospital Records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]							INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hepatic Coma							4 days
DUE TO (b) Laennec's cirrhosis of liver							4 yrs
DUE TO (c) Laennec's cirrhosis of liver							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED White at work <input type="checkbox"/> Not white at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Sept. 3, 1957 , to Dec. 3, 1957 , that I last saw the deceased alive on Dec. 3, 1957 , and that death occurred at 5:15 P.M. from the causes and on the date stated above.							
ADDRESS (Street, city or town, state)				DATE SIGNED			
ACTUAL SIGNATURE Dr. J. Juerman				M.D. Deer's Head State Hospital 12/4/57			
PHYSICIAN'S NAME (Type) V. Juerman, M. D.				Salisbury, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12-8-57		22c. NAME OF CEMETERY OR CREMATORY Brewer Hill		22d. LOCATION (City, town, or county) (State) Annapolis Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE William Reese #108				24a. REC'D BY REGISTRAR 12/9/57			
ADDRESS 108 West St. Annapolis Md				24b. REGISTRAR'S SIGNATURE Mary J. Holloway			

MEDICAL CERTIFICATION

BUREAU A. S.

RECEIVED

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13749

13732 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

337

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Delmar</u>	
c. LENGTH OF STAY IN 1b <u>9 days</u>		d. STREET ADDRESS <u>8 Maryland Ave.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Peninsula General Hospital</u>			
3. NAME OF DECEASED (Type or print) <u>Mary Elizabeth Hitchens</u>		4. DATE OF DEATH <u>12-20-1957</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb 2, 1892</u>
9. AGE (In years last birthday) <u>65 yrs.</u>		10. IF UNDER 1 YEAR: Months <u>12</u> Days <u>20</u> Hours <u>57</u> Min <u>57</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Practical Nurse</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U S A</u>	
13. FATHER'S NAME <u>James Wilson</u>		14. MOTHER'S MAIDEN NAME <u>Sarah Hitchens</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>214-30-8695</u>	
17. INFORMANT <u>Arthur Hitchens, Delmar, Md.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute congestive heart failure</u> 916.7 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>2nd and 3rd degree burns of 80% of body surface.</u> DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH <u>Sudden.</u> <u>9 days</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) <u>Clothing caught fire when stove exploded.</u>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>12-11-</u> 19 <u>57</u> p. m.		20d. INJURY OCCURRED While <input checked="" type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Nursing home.</u> 20f. (City or town) <u>Delmar</u> (County) <u>Md.</u> (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Earl L. Royer</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>Earl L. Royer, M.D.</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <u>12-23-57</u>	
22a. BURIAL, CREMATION, REMOVAL (Type) <u>Burial</u>		22b. DATE THEREOF <u>12-22-57</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>First Methodist</u>		22d. LOCATION (City, town, or county) <u>Delmar, Del.</u> (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <u>W. S. Mansel Co. - Delmar, Kent</u>		24a. REC'D BY REGISTRAR <u>DEC 27 1957</u>	
24b. REGISTRAR'S SIGNATURE <u>Mary H. Holloway</u>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

DEC 07 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13769

CERTIFICATE OF DEATH

13750

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Wicomico</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Delmar Md.</u>		c. LENGTH OF STAY IN 1b <u>Delmar Md. X</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Holloway Nursing Home</u>		d. STREET ADDRESS <u>/</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Levin</u> Middle <u>Franklin</u> Last <u>Holbrook</u>		4. DATE OF DEATH Month <u>12</u> Day <u>5</u> Year <u>1957</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Colored</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>not known about 88</u> yrs.
9. AGE (In years last birthday) <u>88</u> yrs.		10. IF UNDER 1 YEAR: Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Former Teacher</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Md.</u>	
11. BIRTHPLACE (State or foreign country) <u>Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Stanley Holbrook</u>		14. MOTHER'S MAIDEN NAME <u>Ella Smith</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>Gladys Brown Sharptown Md.</u>	
17. INFORMANT <u>Gladys Brown Sharptown Md.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis</u> DUE TO (b) <u>Arterio-sclerotic Heart Disease</u> DUE TO (c) <u>Hypertension</u> CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>			
INTERVAL BETWEEN ONSET AND DEATH <u>7 days</u> <u>Unknown</u> <u>Unknown</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u> </u> p. m. <u> </u> 19 <u>57</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Nov 22</u> , 19 <u>57</u> , to <u>Dec 5</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>Dec 2</u> , 19 <u>57</u> , and that death occurred at <u>6</u> P. M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>G. Herbert Dembly</u> M.D.		ADDRESS (Street, city or town, state) <u>Salisbury Md</u> DATE SIGNED <u>12/6/57</u>	
PHYSICIAN'S NAME (Type) <u>G. Herbert Dembly</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>12 9 / 57</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Green Acres</u>		22d. LOCATION (City, town, or county) (State) <u>Salisbury Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Clinton E. Stewart</u>		ADDRESS <u>Salisbury Md.</u>	
24a. REC'D BY REGISTRAR <u>DEC 9 57</u>		24b. REGISTRAR'S SIGNATURE <u>G. L. Smith</u>	

U. S. DEPT. OF JUSTICE

RECEIVED

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13733 CERTIFICATE OF DEATH

1375B32

Reg. Dist. No. 261

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Somerset	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. LENGTH OF STAY IN 1b 2½ mo.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Deer's Head State Hospital		d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First William Middle --- Last Horsey		4. DATE OF DEATH Month December Day 6th , Year 19 57	
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH AUG-28-1877
9. AGE (In years last birthday) 80 yrs.		IF UNDER 1 YEAR: Months --- Days --- Hours --- Min ---	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY ---	
11. BIRTHPLACE (State or foreign country) Marion Station, Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Thomas Lord		14. MOTHER'S MAIDEN NAME Eliza Gale	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Unk. (If yes, give war or dates of service)		16. SOCIAL SECURITY NO 215-16-8180	
17. INFORMANT Address Deer's Head State Hospital, Salisbury, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic Cardiovascular Disease 424.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerosis, generalized DUE TO (c) ---			INTERVAL BETWEEN ONSET AND DEATH ?
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) ---			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from September 23 19 57 , to December 6 19 57 , that I last saw the deceased alive on December 6, 19 57 , and that death occurred at 7:40 PM , from the causes and on the date stated above.			
ACTUAL SIGNATURE L. V. Maldve		DATE SIGNED 12/7/57	
PHYSICIAN'S NAME (Type) L. V. Maldve, M. D.		M.D. Deer's Head State Hospital Salisbury, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORIUM	22d. LOCATION (City, town, or county) (State)
Burial	Dec. 11, '57	Family Cemetery	Marion Sta, Som. Co, Md.
23. FUNERAL DIRECTOR'S SIGNATURE Charles H. Ward		24a. REC'D BY REGISTRAR 12-11-57	
ADDRESS Marion Sta, Md.		24b. REGISTRAR'S SIGNATURE Mary H. Holloway	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be used as needed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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DEC 13 1957

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13734

CERTIFICATE OF DEATH

13752

Reg. Dist. No.

332

1. PLACE OF DEATH a. COUNTY <u>Wilcomco</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution, residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Wicacosta</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Berlin</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>PENINSULA General Hospital</u>		d. STREET ADDRESS <u>B.F.D.#2</u>	
3. NAME OF DECEASED (Type or print) First <u>Charles</u> Middle <u>Hudson</u> Last <u>Hudson</u>		4. DATE OF DEATH Month <u>December</u> Day <u>16</u> Year <u>1957</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Colored</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12-16-1867</u>
9. AGE (In years last birthday) <u>90</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FARMER</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FARMER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>FARMING</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John A. Hudson</u>		14. MOTHER'S MAIDEN NAME <u>Annie Puth</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>None</u>		16. SOCIAL SECURITY NO. <u>NONE</u>	
17. INFORMANT <u>The. Rudolph Hudson, Berlin, Md.</u>		Address <u>Berlin, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>445X</u> DUE TO <u>Congestive Heart Disease & failure</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Chronic Myocarditis</u> (c) <u>Hypertension</u>		INTERVAL BETWEEN ONSET AND DEATH <u>few days</u> <u>unk!</u> <u>unk</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Dec. 15, 1957</u> to <u>Dec. 16, 1957</u> , that I last saw the deceased alive on <u>19</u> , and that death occurred at <u>12:28 A.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>G. Herbert Sembly</u> M.D.		ADDRESS (Street, city or town, state) <u>Salisbury, Md.</u>	
PRINTED NAME (Type) <u>G. Herbert Sembly</u>		DATE SIGNED <u>12/19/57</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>12-19-1957</u>	22c. NAME OF CEMETERY OR CREMATORY <u>EVERGREEN CEMETERY</u>	22d. LOCATION (City, town, or county) (State) <u>BERLIN, MD</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>J.F. Stewart</u>		24. REC'D BY REGISTRAR <u>REC 2</u>	
ADDRESS <u>FUNERAL HOME, SALISBURY</u>		24b. REGISTRAR'S SIGNATURE <u>Mary H. Holloway</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED
JEC 27 1957
BUREAU V. S.

13735 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>Wicomico</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SALISBURY</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SALISBURY, MD</u>			
c. LENGTH OF STAY IN 1b				d. STREET ADDRESS			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>PENINSULA GENERAL HOSP.</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Goldie</u> Middle <u>ISAAC</u> Last <u>ISAAC</u>				4. DATE OF DEATH Month <u>December</u> Day <u>13</u> Year <u>1957</u>			
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>APRIL 18, 1884</u>	
9. AGE (In years last birthday) <u>73</u> yrs.		IF UNDER 1 YEAR		IF UNDER 24 HRS			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Delaware</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Owen Isaac</u>				14. MOTHER'S MAIDEN NAME <u>Nancy Jane Marvel</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>no</u> (If yes, give war or dates of service)				17. INFORMANT <u>Mrs. Clara Dodds, Philadelphia, Pa.</u> Address <u>5041 N. Fairhill St.</u>			
16. SOCIAL SECURITY NO.							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary thrombosis - acute</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arteriosclerotic heart disease</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) _____ (County) _____ (State) _____							
21. I certify that I attended the deceased from <u>11-6-1957</u> to <u>12-13-1957</u> , that I last saw the deceased alive on <u>Dec. 13</u> , 19 <u>57</u> , and that death occurred at <u>11:30</u> A.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Anthony Bernardo</u> M.D.				ADDRESS (Street, city or town, state) <u>Peninsula Gen. Hosp. Salisbury, Md.</u>			
PHYSICIAN'S NAME (Type) _____				DATE SIGNED <u>12/13/57</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>12/17/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Odd Fellows</u>		22d. LOCATION (City, town, or county) (State) <u>Milford, Del.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>W. B. Berry, Jr.</u> ADDRESS <u>Milford, Del.</u>				24. RECEIVED BY REGISTRAR <u>DEC 11 1957</u> DATE		24b. REGISTRAR'S SIGNATURE <u>Mary Holloway</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

DEC 10 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13770

CERTIFICATE OF DEATH

13754

Reg. Dist. No.

332

1. PLACE OF DEATH a. COUNTY Wicomico b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Pittsville c. LENGTH OF STAY IN 1b Pittsville d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION In Village		2. USUAL RESIDENCE (Where deceased lived. If institut on: Residence before admission) a. STATE Maryland b. COUNTY Wicomico c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Pittsville d. STREET ADDRESS In village e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First GEORGE Middle TILTON Last JACKSON		4. DATE OF DEATH Month December Day 30th Year 57	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH October 17, 1876
9. AGE (In years last birthday) 81 yrs.		10. IF UNDER 1 YEAR Months 2 Days 13	11. IF UNDER 24 HRS Hours 19 Min 57
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer - Carpenter		10b. KIND OF BUSINESS OR INDUSTRY Construction	
11. BIRTHPLACE (State or foreign country) Tilghmans Island, Maryland		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME George Jackson		14. MOTHER'S MAIDEN NAME Ellen Marshall	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no or unknown) Unk		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)	
17. INFORMANT Mrs. Elsie J. Jackson (Wife)		Address Pittsville, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Symptomatic heart failure. DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) degenerative heart disease. DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH 5 yrs.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 10/15 19 57 , to 12/30 19 57 , that I last saw the deceased alive on 12/29 19 57 , and that death occurred at 8:15 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Salisbury, Md. DATE SIGNED Dec. 30/57			
ACTUAL SIGNATURE Earl Beardsley M.D.		PHYSICIAN'S NAME (Type) Dr. Earl Beardsley	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial-		22b. DATE THEREOF Jan. 2, 1957	22c. NAME OF CEMETERY OR CREMATORY Pittsville Cemetery
22d. LOCATION (City, town, or county) Pittsville, Maryland		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE HOLLOWAY & COMPANY FUNERAL HOME - SALISBURY, MD.		24a. REC'D BY REGISTRAR Mary Holloway	
24b. REGISTRAR'S SIGNATURE		DATE 1957	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

JAN 3 1908

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13771 CERTIFICATE OF DEATH

13755

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Tyaskin</u>				c. LENGTH OF STAY IN 1b <u>Lifetime</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS <u>1</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last <u>MAMIE</u> <u>INSLEY</u> <u>JARRETT</u>				4. DATE OF DEATH Month Day Year <u>Dec.</u> <u>22</u> <u>19 57</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7/20/95</u>		9. AGE (In years lost birthday) yrs. <u>62</u>	10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min. <u>5</u> <u>2</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>United States</u>							
13. FATHER'S NAME <u>Slemons S. Jarrett</u>				14. MOTHER'S MAIDEN NAME <u>Virginia Messick</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>-----</u>		17. INFORMANT Address <u>Arlie Jarrett, Tyaskin, Maryland</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage.</u> <u>331x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cerebral Arteriosclerosis</u> DUE TO (c) <u>?</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>?</u>						INTERVAL BETWEEN ONSET AND DEATH <u>1 hour</u> <u>?</u> <u>Cerebral</u>	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>7/28</u> , 19 <u>56</u> to <u>12/22</u> , 19 <u>57</u> that I last saw the deceased alive on <u>12/22</u> , 19 <u>57</u> , and that death occurred at <u>12 P.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Nanticoke Md.</u> DATE SIGNED <u>12/24/57</u>							
ACTUAL SIGNATURE <u>Richard H. Saunders</u> M.D.				PHYSICIAN'S NAME (Type) <u>Richard H. Saunders</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				22b. DATE THEREOF <u>12/26/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Tyaskin Cem.</u>	
22d. LOCATION (City, town, or county) (State) <u>Tyaskin, Maryland</u>							
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. Messick</u> ADDRESS <u>Bivalve, Maryland</u>				24a. RECEIVED BY REGISTRAR <u>Jan 8</u> DATE		24b. REGISTRAR'S SIGNATURE <u>W. J. Messick</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3, 4, 5, 6, 7, 8, 9, 10, 11, 12 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1, 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED
JAN 8 1955
NAVY U. S.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, by the funeral director, page 3 and 4 be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar print to burial, cremation, or in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 7 3-22-57 1-3-58 et

13736

CERTIFICATE OF DEATH

13750 332
Reg. Dist. No. 264-

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Somerset</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>Peninsula General Hospital</u>				d. STREET ADDRESS <u>RT. #1 - Box 366</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) <u>Nathaniel</u> First Middle Last				4. DATE OF DEATH <u>December 19 1957</u> Month Day Year			
5. SEX <u>male</u>		6. COLOR OR RACE <u>colored</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>11-6-1906</u>	
9. AGE (In years last birthday) <u>51</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		11. BIRTHPLACE (State or foreign country) <u>MARION SOMERSET U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Levin Johnson</u>				14. MOTHER'S MAIDEN NAME <u>Sarah MARSHALL</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>217-05-8071</u>			
17. INFORMANT <u>FAELYN JOHNSON, MARION M</u> Address							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Acute Posterior Myocardial Infarction</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic Cardiovascular Dis.</u> DUE TO (c) <u>Congestive Heart Failure</u>				INTERVAL BETWEEN ONSET AND DEATH <u>4 weeks</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Congestive Heart Failure</u>				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>12/17</u> , 19 <u>57</u> , to <u>12/19</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>12/18</u> , 19 <u>57</u> , and that death occurred at <u>6:00 a.m.</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Rufus S. Gardner, Jr.</u> M.D.				ADDRESS (Street, city or town, state) <u>321 S. D. St. Salisbury, Md.</u>			
DATE SIGNED <u>12/20/57</u>							
PHYSICIAN'S NAME (Type) <u>Rufus S. Gardner, Jr.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>12/22/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>John Wesley</u>		22d. LOCATION (City, town, or county) (State) <u>Marion Sta. Soc. Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Charles H. Ward</u> ADDRESS <u>Marion Sta. Md.</u>				24a. REC'D BY REGISTRAR <u>12-22-57</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur B. Payne</u>	

RECEIVED
DEC 11 1957
BUREAU V. S.

13772

CERTIFICATE OF DEATH

Reg. Dist. No. 33 ✓

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution. Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Wicomico</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Head Of Creek</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Quantico</u> X	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS <u>/</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Ida</u> Middle <u>B.</u> Last <u>Jones</u>		4. DATE OF DEATH Month <u>12</u> Day <u>10</u> Year <u>1957</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Colored</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Unknown</u>
9. AGE (In years last birthday) <u>82</u> yrs.		IF UNDER 1 YEAR Months <u></u> Days <u></u>	IF UNDER 24 HRS Hours <u></u> Min. <u></u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Domestic</u>		10b. KIND OF BUSINESS OR INDUSTRY <u></u>	11. BIRTHPLACE (State or foreign country) <u>Maryland</u>
12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>			
13. FATHER'S NAME <u>Unknown</u>		14. MOTHER'S MAIDEN NAME <u>Amanda Robinson</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no.</u>		16. SOCIAL SECURITY NO. <u></u>	
17. INFORMANT <u>Mathew Jones</u>		Address <u>Quantico Md. R. F. 1</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> DUE TO (b) <u>Arterio Sclerotic Heart Disease</u> DUE TO (c) <u></u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH <u>24 hours</u> <u>16 years</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <u></u> a. m. <u></u> p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>11/1</u> , 19 <u>54</u> , to <u>12/10</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>12/10</u> , 19 <u>57</u> , and that death occurred at <u>2 P.</u> M. from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Richard H. Saunders</u> M.D.		ADDRESS (Street, city or town, state) <u>Nantuxville Md.</u>	
PHYSICIAN'S NAME (Type) <u>RICHARD H. SAUNDERS.</u>		DATE SIGNED <u>12/12/57</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>12/15/57</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Head of Creek</u>		22d. LOCATION (City, town, or county) (State) <u>Wicomico Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Clinton F. Stewart</u>		24a. REC'D BY REGISTRAR <u>DEC 18</u>	
ADDRESS <u>Salisbury Md.</u>		24b. REGISTRAR'S SIGNATURE <u>Mary Holloway</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BRUNNEN V. S.

DEC 1 7

RECEIVED

DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1
FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13737

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13758 337

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> <u>MARYLAND</u>		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>Delaware</u> b. COUNTY <u>Sussex</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>		c. LENGTH OF STAY IN 1b <u>7 days</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Peninsula General Hospital</u>		e. STREET ADDRESS <u>Dagsboro, Delaware</u>	
3. NAME OF DECEASED (Type or print) <u>Ruby Opal Long</u>		4. DATE OF DEATH <u>12-26-57</u> <u>19</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan 5, 1914</u>
9. AGE (in years last birthday) <u>43</u> yrs.		10. IF UNDER 1 YEAR <u>Months</u> <u>Days</u> <u>Hours</u> <u>Min</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Teaching (School)</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Oklahoma</u>	
11. BIRTHPLACE (State or foreign country) <u>U. S. A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>J. A. Crull</u>		14. MOTHER'S MAIDEN NAME <u>Ellen Northrop Crull</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>Harry o. Long</u>	
17. INFORMANT <u>Dagsboro, Del.</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Fractured skull: intracranial hemorrhage. 2 days</u> DUE TO <u>25 X</u> Conditions, if any, which gave rise to immediate cause (b) <u>DOE TO</u> (c) <u>DOE TO</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>INTERVAL BETWEEN ONSET AND DEATH</u> 19. WAS AUTOPSY PERFORMED? <u>YES</u> <input type="checkbox"/> <u>NO</u> <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <u>Injured in an automobile accident. Old Dalmar Rd.</u>	
20c. TIME OF INJURY <u>11:20 A.M. 12-23-57</u> Month Day Year		20d. INJURY OCCURRED <u>While at work</u> <input type="checkbox"/> <u>Not while at work</u> <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Street</u>		20f. (City or town) <u>Salisbury</u> (County) <u>Wicomico</u> (State) <u>Md.</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL <u>Earl L. Royer</u> M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <u>12-27-57</u>	
EXAMINER'S NAME (Type) <u>Earl L. Royer, M.D.</u>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>12-29-57</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Red Mens Cemetery</u>		22d. LOCATION (City, town or county) <u>Dagsboro, Del.</u> (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Watson & Gray Millsboro, Del.</u>		24a. REC'D BY REGISTRAR <u>DEC 31 1957</u> 24b. REGISTRAR'S SIGNATURE <u>Mary Holloway</u>	

RECEIVED

DEC 1977

BUREAU V. S.

CERTIFICATE OF DEATH

Reg. Dist. No. 332

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>Wicomico</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SALISBURY</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>THASKIN</u>			
c. LENGTH OF STAY IN 1b <u>8 DAYS</u>				d. STREET ADDRESS			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>PENINSULA GENERAL HOSPITAL</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>EVELYN</u> Middle <u>MASON</u> Last <u>MASON</u>		4. DATE OF DEATH Month <u>DECEMBER</u> Day <u>2</u> Year <u>1957</u>		5. SEX <u>FEMALE</u>		6. COLOR OR RACE <u>COLORED</u>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>5-3-78</u>		9. AGE (In years last birthday) <u>79</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months <u>7</u> Days <u>7</u> Hours <u>7</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>				13. FATHER'S NAME <u>William Jones</u>			
14. MOTHER'S MAIDEN NAME <u>Mary A. Jones</u>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes or unknown) <u>No</u> (If yes, give war or dates of service)			
16. SOCIAL SECURITY NO. <u>11-3-3-78</u>				17. INFORMANT <u>Blacks, Hatter, Thaskin, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> <u>501X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Generalized Arteriosclerosis</u> DUE TO (c) <u>10 years</u>						INTERVAL BETWEEN ONSET AND DEATH <u>2 weeks</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) <u>NANTICOKE MD</u>				20g. (County) <u>Wicomico</u>		20h. (State) <u>MD</u>	
21. I certify that I attended the deceased from <u>5/27</u> 19 <u>57</u> to <u>12/2</u> 19 <u>57</u> that I last saw the deceased alive on <u>12/2</u> 19 <u>57</u> , and that death occurred at <u>9:00 A.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Richard H. Saunders M.D.</u>				DATE SIGNED <u>12/4/57</u>			
PHYSICIAN'S NAME (Type) <u>RICHARD H. SAUNDERS M.D.</u>				ADDRESS (Street, city or town, state) <u>NANTICOKE MD</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>12/7/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Thaskin, Md.</u>		22d. LOCATION (City, town, or county) (State) <u>Thaskin, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>C. D. Meserub, Pinalva, Md.</u>				24a. REC'D BY REGISTRAR <u>14-C 10 1957</u>		24b. REGISTRAR'S SIGNATURE <u>Mary H. Holloway</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

DEC 1

RECEIVED

13739

CERTIFICATE OF DEATH

Reg. Dist. No.

322

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>Wicomico</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Ocean City</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Frederick General Hospital</u>		d. STREET ADDRESS <u>110 W. Comico St.</u>	
3. NAME OF DECEASED (Type or print) First <u>Wilmer</u> Middle <u>O.</u> Last <u>Messick</u>		4. DATE OF DEATH Month <u>December</u> Day <u>6</u> Year <u>1957</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1-4-87</u>
9. AGE (In years lost birthday) <u>70</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired police</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>UNKNOWN</u>		14. MOTHER'S MAIDEN NAME <u>UNKNOWN</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>214-12-1062A</u>	
17. INFORMANT <u>Family</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Chronic Cor Pulmonale with Congestive Failure</u> <u>434.3</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Pulmonary Infiltration - Cause</u> DUE TO (c) <u>undetermined</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Dec 1</u> , 1957, to <u>Dec 7</u> , 1957, that I last saw the deceased alive on <u>Dec 7</u> , 1957, and that death occurred at <u>2:30 P.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE <u>Thomas C. Hill Jr.</u> M.D.			
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>12-10-57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Wooten Cem.</u>	22d. LOCATION (City, town, or county) (State) <u>Baltimore Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>McCully Funeral Home</u>		ADDRESS <u>1308 Fortune</u>	
24a. REC'D BY REGISTRAR DATE <u>DEC 10 1957</u>		24b. REGISTRAR'S SIGNATURE <u>Mary Holloway</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

S. A. GUTPE

DEANSON

13740

CERTIFICATE OF DEATH

Reg. Dist. No.

332

1 PLACE OF DEATH a. COUNTY Wicomico MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Somerset			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury				c. LENGTH OF STAY IN 1b 14 months			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Deer's Head State Hospital				d. STREET ADDRESS --			
3 NAME OF DECEASED (Type or print) First Dossie Middle Vealie Last Milbourne				4. DATE OF DEATH Month Dec. Day 8, Year 19 57			
5 SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 29, 1878		9. AGE (In years last birthday) 79 yrs.	IF UNDER 1 YEAR Months 79 Days 79 Hours 79 Min 79	IF UNDER 24 HRS Hours 79 Min 79
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) --				10b. KIND OF BUSINESS OR INDUSTRY --		11. BIRTHPLACE (State or foreign country) Deal Island, Md.	
13. FATHER'S NAME Levin Milbourne				12. CITIZEN OF WHAT COUNTRY? USA			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no or unknown) Unk. (If yes, give war or dates of service)				16. SOCIAL SECURITY NO --		17. INFORMANT Address Deer's Head State Hospital, Salisbury, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Ca. of right face 191X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) 191X DUE TO (c) 191X						INTERVAL BETWEEN ONSET AND DEATH Years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from October 3, 1957 to Dec. 8, 1957 that I last saw the deceased alive on Dec. 8, 1957 and that death occurred at 9:55 PM from the causes and on the date stated above.							
ACTUAL SIGNATURE L. V. Maldve				ADDRESS (Street, city or town, state) Deer's Head State Hospital DATE SIGNED 12/9/57			
PHYSICIAN'S NAME (Type) L. V. Maldve, M. D.				Salisbury, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Buried		22b. DATE THEREOF 12/11/57		22c. NAME OF CEMETERY OR CREMATORY Deer's Head State Hospital		22d. LOCATION (City, town, or county) (State) Salisbury, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE L. V. Maldve				ADDRESS Deer's Head State Hospital		24b. REGISTRAR'S SIGNATURE L. V. Maldve	
DATE 12/12/57				24a. REGISTRAR'S SIGNATURE L. V. Maldve		DATE 12/12/57	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

JAN 2 1953

RECEIVED

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
DM 2 57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 13762
13741 MEDICAL EXAMINER'S CERTIFICATE OF DEATH
Item 9 Filed 12-19-57 et

Reg. Dist. No 337

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE Maryland b. COUNTY Wicomico	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 205 Walnut St		d. STREET ADDRESS 205 Walnut Street	
3. NAME OF DECEASED (Type or print) First MIDDLE Last AGNES N MITTEN		4. DATE OF DEATH Month Day Year DECEMBER 1 st 19 57	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 26, Approx. 60 yrs.
9. AGE (in years last birthday)		10. IF UNDER 1 YEAR Months Days	11. IF UNDER 24 HR Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Seamstress		10b. KIND OF BUSINESS OR INDUSTRY Clothing	
11. BIRTHPLACE (State or foreign country) Baltimore Maryland		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME Elmer E. Estes		14. MOTHER'S MAIDEN NAME Theresa Sutton	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO.	
17. INFORMANT Mrs. Wendell Vickers (friend) Cambridge, Maryland		Address 825 Roslyn Ave.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 440.1 Coronary occlusion DUE TO Conditions, if any, which gave rise to immediate cause (b) Hypertensive cardio-vascular disease- (a), stating the underlying cause lost. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH Sudden. Years.			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from. Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Dr. Earl L. Royer		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type) Dr. Earl L. Royer		DATE SIGNED December 2 1957	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Dec. 4, 1957	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State) Chestertown, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE LeCompte Funeral Service - Cambridge, Maryland		24a. REC'D BY REGISTRAR DATE 12/4/57	24b. REGISTRAR'S SIGNATURE John Macdonald Mary H. Williams

MEDICAL CERTIFICATION

BURNETT V. S.

JEC

REGISTERED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
CERTIFICATE OF DEATH

13742

13763

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Wicomico</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MD</u> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SALISBURY</u>			c. LENGTH OF STAY IN 1b <u>4 mo</u>			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CRISFIELD</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>JAMES</u> Middle <u>L.</u> Last <u>NELSON</u>				4. DATE OF DEATH Month <u>12</u> Day <u>19</u> Year <u>1957</u>			
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>JAN 22 1870</u>	
9. AGE (In years last birthday) <u>87</u> yrs		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Merchant (Retired)</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Gen. Merchandise</u>		11. BIRTHPLACE (State or foreign country) <u>Crisfield, Maryland</u>	
						12. CITIZEN OF WHAT COUNTRY? <u>U. S. A</u>	
13. FATHER'S NAME <u>Lorenzo Nelson</u>				14. MOTHER'S MAIDEN NAME <u>Harriett Lawson</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiovascular Renal Disease</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour o. ft. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Aug 22</u> , 19 <u>57</u> , to <u>12-19</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>12-19</u> , 19 <u>57</u> , and that death occurred at <u>10:00 P.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Philip A. Insky</u> M.D.				ADDRESS (Street, city or town, state) DATE SIGNED <u>Salisbury Md 12-20-57</u>			
PHYSICIAN'S NAME (Type) <u>Philip A. Insky</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>DEC. 22, 1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>CRISFIELD CEMETERY</u>		22d. LOCATION (City, town, or county) (State) <u>CRISFIELD, MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>BRIDGEMAN & SONS - CRISFIELD, MD.</u> <u>Robert H. Bridgeman</u>				24. REC'D BY REGISTRAR DATE <u>DEC 23 1957</u>		24b. REGISTRAR'S SIGNATURE <u>Mary Holloway</u> <u>87</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low equi that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, by the funeral director, page 3 shall be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. 1

DEC 19

1900

13743

CERTIFICATE OF DEATH

13764 337

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>Wicomico</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SALISBURY</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SALISBURY</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>PENINSULA GENERAL HOSPITAL</u>		d. STREET ADDRESS <u>404 1/2 CAMDEN AVE.</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>MARY Washington NELSON</u>		4. DATE OF DEATH Month Day Year <u>DECEMBER 2 1957</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>MAR 13-1891</u>
9. AGE (In years last birthday) <u>66</u> yrs		IF UNDER 1 YEAR: Months <u>8</u> Days <u>19</u> Hours <u></u> Min <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House Work</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>	11. BIRTHPLACE (State or foreign country) <u>Salisbury, Maryland</u>
12. CITIZEN OF WHAT COUNTRY? <u>U S A</u>		13. FATHER'S NAME <u>Thomas Henry Purcell</u>	
14. MOTHER'S MAIDEN NAME <u>Ella Rhee Bradley</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>No</u>	
16. SOCIAL SECURITY NO. <u></u>		17. INFORMANT <u>Mrs. Herman E. Coulter (Daughter)</u> <u>Salisbury, Maryland</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Friedland's Pneumonia</u> <u>490X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Diabetes Mellitus</u> DUE TO (c) <u></u>		INTERVAL BETWEEN ONSET AND DEATH <u>10 yrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE <u>260X</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u></u>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u></u>	20f. (City or town) (County) (State) <u></u>
21. I certify that I attended the deceased from <u>11/25</u> , 19 <u>57</u> , to <u>12/2</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>12/1</u> , 19 <u>57</u> , and that death occurred at <u>2:14</u> PM, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Andrew C. Mitchell</u> M.D.		ADDRESS (Street, city or town, state) <u>211 Maryland Ave Salisbury, Md.</u>	
DATE SIGNED <u>12/2/57</u>		PHYSICIAN'S NAME (Type) <u>Dr. Andrew C. Mitchell</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>Dec. 4, 1957</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Wicomico Memorial Park</u>	22d. LOCATION (City, town, or county) (State) <u>Salisbury, Maryland</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>HOLLOWAY & COMPANY FUNERAL HOME</u>		24a. REC'D BY REGISTRAR <u>DEC 5 1957</u>	24b. REGISTRAR'S SIGNATURE <u>Mary Holloway</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

U.S. AIR FORCE

21 - 1

RECEIVED

13773

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) o. STATE Maryland b. COUNTY Wicomico	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Pittsville	c. LENGTH OF STAY IN 1b Life	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Pittsville	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION XXXX		e. STREET ADDRESS 1	f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) GATTIE First HULDA Middle PALMER Last		4. DATE OF DEATH Dec. 14, Month 14, Day 1957 Year	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 16, 1886
9. AGE (In years from birthday) 71 yrs.		10. IF UNDER 1 YEAR: Months 1 Days 14 Hours 19 Mm 57	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home	11. BIRTHPLACE (State or foreign country) Delaware
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Robert Smith	
14. MOTHER'S MAIDEN NAME Rachel Baker		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO. 212-10-9084		17. INFORMANT F. T. Palmer Address Pittsville Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Chronic myocarditis DUE TO Hypertension-arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hypertension-arteriosclerosis DUE TO Hypertension-arteriosclerosis (c) Hypertension-arteriosclerosis			INTERVAL BETWEEN ONSET AND DEATH 2 yrs.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 6 weeks ago - pulmonary infarct (x-ray diagnosis - PG Hospital)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Either nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from October 1, 1957 to 12-14-1957 , that I last saw the deceased alive on 12-14-1957 , and that death occurred at 6:30 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Frank R. Lewis		ADDRESS (Street, city or town, state) Wicomico Maryland DATE SIGNED	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 12/17/57	22c. NAME OF CEMETERY OR CREMATORY Pittsville	22d. LOCATION (City, town, or county) (State) Pittsville, Md.
23. FUNERAL DIRECTOR'S SIGNATURE Peter Whaley		24a. REC'D BY REGISTRAR DEC 23 1957	24b. REGISTRAR'S SIGNATURE Mary Halloway

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 will be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

DEC 13



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 9 Filed 12-30-57 et
13744 **CERTIFICATE OF DEATH**

13769
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Peninsula General Hospital</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Somerset</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Doyle</u> 19x2 in d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Gladys</u> Middle <u>E</u> Last <u>Parks</u> 4. DATE OF DEATH Month <u>December</u> Day <u>8</u> Year <u>1957</u>				5. SEX <u>Female</u> 6. COLOR OR RACE <u>white</u> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH <u>Feb 23, 1884</u> 9. AGE (In years last birthday) <u>48 2/3</u> yrs. IF UNDER 1 YEAR: Months <u>1</u> Days <u>1</u> Hours <u>1</u> Min. <u>1</u> IF UNDER 24 HRS: Months <u>1</u> Days <u>1</u> Hours <u>1</u> Min. <u>1</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>none</u> 11. BIRTHPLACE (State or foreign country) <u>Maryland</u> 12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>		13. FATHER'S NAME <u>William John Tyler</u> 14. MOTHER'S MAIDEN NAME <u>Estella Jones</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give year or dates of service) 16. SOCIAL SECURITY NO. <u>219-16-4794</u> 17. INFORMANT <u>Mr. Walter Parks</u> Address <u>Orville Mc</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Carcinoma of Breast - Metastases to Brain, fracture left hip</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)		20c. TIME OF INJURY Month, Day, Year Hour o. m. _____ p. m. _____ 19____ 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) _____ (County) _____ (State) _____			
21. I certify that I attended the deceased from <u>Nov. 15, 1957</u> to <u>Dec. 8, 1957</u> , that I last saw the deceased alive on <u>Dec. 8, 1957</u> , and that death occurred at <u>10:30 P.M.</u> , from the causes and on the date stated above. ACTUAL SIGNATURE <u>Levin Wilson</u> M.D. ADDRESS (Street, city or town, state) <u>Salisbury Md</u> DATE SIGNED <u>Dec. 8, 1957</u> PHYSICIAN'S NAME (Type) _____							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> 22b. DATE THEREOF <u>12-11-57</u> 22c. NAME OF CEMETERY OR CREMATORY <u>Orville Cemetery</u> 22d. LOCATION (City, town, or county) <u>Orville Md</u> (State) _____		23. FUNERAL DIRECTOR'S SIGNATURE <u>Levin Wilson</u> ADDRESS <u>Princes Anne</u> 24a. REC'D BY REGISTRAR <u>Mary Holloway</u> DATE <u>12-11-57</u> 24b. REGISTRAR'S SIGNATURE					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. The funeral director, after this certificate has been signed by the attending physician and completely filled in, should be filed with page 3. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

W. A. OVERMAN

1917

1917

CERTIFICATE OF DEATH

Reg. Dist. No.

1376337

13745

1 PLACE OF DEATH a. COUNTY Wicomico b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury c. LENGTH OF STAY IN 1b 12 d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 104 Union Ave.		2 USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE Maryland b. COUNTY Wicomico c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury d. STREET ADDRESS 104 Union Ave. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Clara Middle Esther Last Parsons		4. DATE OF DEATH Month Dec. Day 10 Year 1957	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 1, 1903.
9. AGE (In years last birthday) 54		IF UNDER 1 YEAR Months 5 Days 10 Hours 19 Min.	IF UNDER 24 HRS. Hours 19 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Wife		10b. KIND OF BUSINESS OR INDUSTRY At Home	11. BIRTHPLACE (State or foreign country) Delmar Maryland.
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME John Greensbury Parsons	
14. MOTHER'S MAIDEN NAME Laxenia Elizabeth Hastings.		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, give war or dates of service) NO	
16. SOCIAL SECURITY NO 1-0		17. INFORMANT Mr. Purnell W. Parsons (Husband) Address 104 Union Ave. Salisbury, Maryland.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of breasts with metastases throughout both lungs and left femur DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH 3 years	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month 19 Day 19 Hour a. m. p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 1954 to Dec 10 19 57 , that I last saw the deceased alive on Dec 8 19 57 , and that death occurred at 1:30 PM , from the causes and on the date stated above.			
ACTUAL SIGNATURE L.V. Sohler M.D.		ADDRESS (Street, city or town, state) 303 East Street Delmar DATE SIGNED 12-10-57	
PHYSICIAN'S NAME (Type) Dr. L.V. Sohler		303 East Street, Delmar, Maryland.	
22a. BURIAL CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Dec. 12, 57.	22c. NAME OF CEMETERY OR CREMATORY Parsons Cemetery.	22d. LOCATION (City, town, or county) (State) Salisbury, Maryland.
23. FUNERAL DIRECTOR'S SIGNATURE Holloway & Company.		ADDRESS Salisbury, Maryland.	
24a. REC'D BY REGISTRAR DATE		24b. REGISTRAR'S SIGNATURE Mary H. Holloway	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 2 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RONALD V. B.

DEPT. A

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13746

CERTIFICATE OF DEATH

13768 337
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE Maryland b. COUNTY Wicomico			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION D.C.A. Pen. Gen. Hospital				d STREET ADDRESS 133 Traitt			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3 NAME OF DECEASED (Type or print) ADDIE		First MARIE Last PHILLIPS		4. DATE OF DEATH Month DECEMBER Day 22 Year 19 57			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH April 30, 1920		9. AGE (In years last birthday) 37 yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Work at Home		10b. KIND OF BUSINESS OR INDUSTRY None		11 BIRTHPLACE (State or foreign country) Salisbury, Maryland		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME Sydney E. Lewis				14. MOTHER'S MAIDEN NAME Sarah Elizabeth Moore			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) No		16 SOCIAL SECURITY NO		17. INFORMANT Mr. E. Carlyle Phillips (Husband) Address 133 Traitt St Salisbury, Maryland			
18. CAUSE OF DEATH [Enter only one cause on line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary + Cardiac infarctosis DUE TO Carcinoma of left breast Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c) INTERVAL BETWEEN ONSET AND DEATH 1 mon 15 mo.							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Hour a. m. p. m. 19	Month. 12	Day. 22	Year. 1957	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f (City or town) (County) (State)	
21. I certify that I attended the deceased from 8:15 1956 , to 12:22 1957 , that I last saw the deceased alive on 12:22 1957 , and that death occurred at 4:15 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED							
SIGNATURE H. Briele M.D.							
PHYSICIAN'S NAME (Type) Dr. Henry Briele				Medical Center - Salisbury, Maryland Dec. 23/57			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Dec. 24, 1957		22c. NAME OF CEMETERY OR CREMATORY Parsons Cemetery		22d. LOCATION (City, town, or county) (State) Salisbury, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE HOLLOWAY & COMPANY FUNERAL HOME * SALISBURY, MD.				24a. REC'D BY REGISTRAR DEC 27 1957		24b. REGISTRAR'S SIGNATURE Mary N. Holloway	

DEC 27 1957

BUREAU V.

RECEIVED

13747 CERTIFICATE OF DEATH

Reg. Dist. No.

1376033y

1. PLACE OF DEATH a. COUNTY <u>WICOMICO</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>WORCESTER</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SALISBURY</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RURAL - POCOMOKE CITY</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>SPRING HILL NURSING HOME</u>				d. STREET ADDRESS <u>RFD #2</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>LOUISE H. PILCHARD</u>				4. DATE OF DEATH Month Day Year <u>DEC. 9 1957</u>			
5. SEX <u>FEMALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>NOV. 3, 1879</u>	
9. AGE (In years last birthday) <u>78</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>							
13. FATHER'S NAME <u>CHARLES T. ARDIS</u>				14. MOTHER'S MAIDEN NAME <u>HARRIETT BONNEVILLE</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>231-46-3172</u>		17. INFORMANT Address <u>MRS GEORGE WATERFIELD, POCOMOKE, MD.</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral thrombosis</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>—</u> DUE TO (c) <u>—</u>						INTERVAL BETWEEN ONSET AND DEATH <u>2 months</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>10-9</u> , 19 <u>57</u> , to <u>12-9</u> , 19 <u>57</u> that I last saw the deceased alive on <u>12-9</u> , 19 <u>57</u> , and that death occurred at <u>3 P</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>William E. Ellis, Jr.</u> M.D.				ADDRESS (Street, city or town, state) <u>Salisbury, Md.</u> DATE SIGNED <u>12-9-57</u>			
PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>12-13-57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>BAPTIST CEMETERY</u>		22d. LOCATION (City, town, or county) (State) <u>POCOMOKE CITY, MARYLAND</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Henry A. Tatom</u>				ADDRESS <u>POCOMOKE, MD.</u>		24a. REC'D BY REGISTRAR DATE <u>DEC 16 1957</u>	
				24b. REGISTRAR'S SIGNATURE <u>Mary J. Holloway</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
page 3 of 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 & 2 should be filed with
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

NOV 17 1957

RECEIVED

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>WILCOMING</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institutional: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>Worcester</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Worcester</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>PENINSULA General Hospital</u>				d. STREET ADDRESS <u>Baltimore Ave</u>			
3. NAME OF DECEASED (Type or print) First <u>William</u> Middle <u>A.</u> Last <u>Pitts</u>				4. DATE OF DEATH Month <u>December</u> Day <u>4</u> Year <u>1957</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>Colored</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>9-14-1910</u>	
9. AGE (In years last birthday) <u>47</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>LABORER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>STORES</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Alex Birkhead</u>		14. MOTHER'S MAIDEN NAME <u>CLARA PITS</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>579-14-7965</u>				16. SOCIAL SECURITY NO. <u>579-14-7965</u>			
17. INFORMANT <u>Willie R. Ellis Jr.</u>				Address <u>Salisbury, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Degenerative Heart Disease</u>							
+22.1 DUE TO							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>contusion</u>							
DUE TO							
(c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour <u>19</u> o. m. p. m.				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>12-4</u> , 19 <u>57</u> , to <u>12-4</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>12-4</u> , 19 <u>57</u> , and that death occurred at <u>5:30 A.M.</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Willie R. Ellis Jr.</u> M.D. <u>Salisbury, Md.</u>				DATE SIGNED <u>12-4-57</u>			
PHYSICIAN'S NAME (Type) <u>Willie R. Ellis Jr.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>12-8-1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>EVERGREEN CEMETERY</u>		22d. LOCATION (City, town, or county) (State) <u>BERLIN, MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>J.F. Stewart</u> ADDRESS <u>Funeral Home, Salisbury, Md.</u>				24a. REC'D BY REGISTRAR <u>Harry H. Holloway</u>		24b. REGISTRAR'S SIGNATURE <u>Harry H. Holloway</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

200000 Y. S.

1000000

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13749

CERTIFICATE OF DEATH

1377537
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Wicomico			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Pen. Gen. Hospital				d. STREET ADDRESS Main St			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First WILLARD Middle LEONARD Last PUSEY				4. DATE OF DEATH Month DECEMBER Day 29th Year 19 57			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 7, 1906	9. AGE (In years last birthday) yrs. 51	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Lumberman		10b. KIND OF BUSINESS OR INDUSTRY Lumber		11. BIRTHPLACE (State or foreign country) Princess Anne, Maryland		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME Jefferson D. Pusey				14. MOTHER'S MAIDEN NAME Pearl Heath			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) Unk (If yes, give war or dates of service)		16. SOCIAL SECURITY NO		17. INFORMANT Address Mrs. Helen J. Pusey (Wife) Fruitland, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia DUE TO Pericarditis, Adhesions Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Phlebotomy (Arteries) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) JOIX							INTERVAL BETWEEN ONSET AND DEATH 1 yr.
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Dec 12/28 19 57 to 12/29 19 57 that I last saw the deceased alive on 12/28 19 57 , and that death occurred at 12:25 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 321 S. DIV. ST. DATE SIGNED Dec. 130 57							
ACTUAL SIGNATURE Dr. Rufus S. Gardner Jr.		PHYSICIAN'S NAME (Type) Dr. Rufus S. Gardner Jr. S. Division St. Salisbury, Maryland					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Dec. 31, 1957		22c. NAME OF CEMETERY OR CREMATORY Wicomico Memorial Park		22d. LOCATION (City, town, or county) (State) Salisbury, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE HOLLOWAY & COMPANY FUNERAL HOME - SALISBURY, MD.				24. REGD BY REGISTRAR DATE 1 JAN		24b. REGISTRAR'S SIGNATURE Mary H. Holloway	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar, prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

JAN 3 1958

RECEIVED

13750

CERTIFICATE OF DEATH

Reg. Dist. No.

1 PLACE OF DEATH a COUNTY Wicomico MARYLAND				2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a STATE Maryland b COUNTY Baltimore City			
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury				c LENGTH OF STAY IN 1b 5½ years			
d NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Deer's Head State Hospital				e STREET ADDRESS 31 N. Carey Street			
3 NAME OF DECEASED (Type or print) First Nellie Middle Putsche Last Putsche				4 DATE OF DEATH Month December Day 11 Year 19 57			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8 DATE OF BIRTH 7/19/1872	
9. AGE (In years last birthday) yrs. 85		IF UNDER 1 YEAR Months 8 Days 11 Hours 11 Min 57		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) -		10b. KIND OF BUSINESS OR INDUSTRY -	
11 BIRTHPLACE (State or foreign country) Maryland				12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME Frederick Putsche				14. MOTHER'S MAIDEN NAME Nellie Manning			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) Unk.				16. SOCIAL SECURITY NO -		17. INFORMANT Hospital Records	
18 CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral thrombosis DUE TO Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause last. Generalized arteriosclerosis DUE TO (c) -						INTERVAL BETWEEN ONSET AND DEATH 10 days Years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour 19 o. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from April 1, 19 52 to December 11 57 , that I last saw the deceased alive on Dec. 11, 19 57 , and that death occurred at 4:25 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Deer's Head State Hospital DATE SIGNED 12/12/57							
ACTUAL SIGNATURE L. V. Maldve, M. D.				M.D. Deer's Head State Hospital			
PHYSICIAN'S NAME (Type) L. V. Maldve, M. D.				Salisbury, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Dec. 16, 1957		22c. NAME OF CEMETERY OR CREMATORY Parsons Cemetery		22d. LOCATION (City, town, or county) (State) Salisbury, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE HOLLOWAY & COMPANY FUNERAL HOME - SALISBURY, MD.				24a. RECEIVED BY REGISTRAR DEC 16 1957			
24b. REGISTRAR'S SIGNATURE Mary Holloway							

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. B.

DEC 16 1937

RECEIVED

13751

CERTIFICATE OF DEATH

13773

Reg. Dist. No.

332

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Cecil			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury				c. LENGTH OF STAY IN 1b 13 months			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Deer's Head State Hospital				d. STREET ADDRESS			
3. NAME OF DECEASED (Type or print) First Marshall Middle A. Last Ragan				4. DATE OF DEATH Month Dec. Day 29 Year 1957			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH 9/1/1895	
9. AGE (In years last birthday) 62 yrs.		IF UNDER 1 YEAR Months 62 Days 29 Hours 19 Min. 57		IF UNDER 24 HRS			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter				10b. KIND OF BUSINESS OR INDUSTRY Carpenter		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME Stephen Ragan				14. MOTHER'S MAIDEN NAME Mabel Alexander			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Unk.				16. SOCIAL SECURITY NO		17. INFORMANT Hospital Records	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial insufficiency 422.2 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Degenerative heart disease DUE TO (c)				INTERVAL BETWEEN ONSET AND DEATH 1 week 10 yrs			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Rheumatoid arthritis				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o m 19 p. m.				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from Nov. 13, 1956 , to Dec. 29, 1957 , that I last saw the deceased alive on Dec. 29, 1957 , and that death occurred at 11:05 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE Dr. V. Juerman M.D.				Deer's Head State Hospital 12/30/57			
PHYSICIAN'S NAME (Type) Dr. V. Juerman				Salisbury, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Jan 2 1958		22c. NAME OF CEMETERY OR CREMATORY Pleasant Grove Pa, near Peach Bottom Pa.		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE J. Carl Tyson, Rising Sun, Md.				24a. REC'D BY REGISTRAR JAN 2 1958		24b. REGISTRAR'S SIGNATURE Mary H. Holloway	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician on.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3, 4 and 5 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED
JAN 2 1 3
BUREAU V. R.

CERTIFICATE OF DEATH

13774337
Reg. Dist. No.

13752

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Winnsboro General Hospital</u>				d STREET ADDRESS <u>West St.</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3 NAME OF DECEASED (Type or print) First Middle Last <u>FLORENCE B. RAYNE</u>				4. DATE OF DEATH Month Day Year <u>December 12 1957</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>JAN. 27, 1888</u>	9. AGE (In years last birthday) <u>69</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>PRACTICAL NURSE</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>OWN HOME</u>		11. BIRTHPLACE (State or foreign country) <u>BERLIN MD RFD</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S. A</u>							
13. FATHER'S NAME <u>SEWELL DEYNNIS</u>				14. MOTHER'S MAIDEN NAME <u>SUSAN HOLLAND</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give year or dates of service) <u>No</u>				16. SOCIAL SECURITY NO.			
17. INFORMANT <u>MRS EUNICE FISITER</u>				Address <u>BERLIN MD</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>1) HEPATIC FAILURE</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>2) ADENOCARCINOMA, HEPATIC</u> DUE TO (c) <u>3) CARCINOMA, G-I TRACT(?)</u>							INTERVAL BETWEEN ONSET AND DEATH <u>3 WKS.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>11/28</u> , 19 <u>57</u> , to <u>12/12</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>12/12</u> , 19 <u>57</u> , and that death occurred at <u>11:22 PM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Rufus S. Gardner Jr.</u> M.D.				ADDRESS (Street, city or town, state) <u>321 S. Div St., Salisbury MD</u>			
DATE SIGNED <u>12/13/57</u>							
PHYSICIAN'S NAME (Type) <u>RUFUS S. GARDNER JR.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>12/15/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>BUCKINGHAM</u>		22d. LOCATION (City, town, or county) (State) <u>BERLIN MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Anna H. Burbage</u>				ADDRESS <u>Berlin MD</u>		24a. REC'D BY REGISTRAR <u>DEC 16 1957</u>	
				24b. REGISTRAR'S SIGNATURE <u>Mary J. Holloway</u>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 of this certificate should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

DEC 1 1967

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13753 CERTIFICATE OF DEATH

13775337
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution. Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>Wicomico</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>PENINSULA GEN Hosp</u>				d. STREET ADDRESS <u>504 COLLINS ST.</u>			
3. NAME OF DECEASED (Type or print) <u>Elmer</u> First <u>D. Shockley</u> Middle <u>Shockley</u> Last				4. DATE <u>DEATH</u> Month <u>12</u> Day <u>12</u> Year <u>1957</u>			
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>A.A.</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7-4-1896</u>		9. AGE (In years last birthday) <u>61</u> yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS Months <u>-</u> Days <u>-</u> Hours <u>-</u> Min <u>-</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>LABORER</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>CHICKEN PLANT</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>Kate Shockley</u>				14. MOTHER'S MAIDEN NAME <u>Nora Shockley</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>NO</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>214-16-9802</u>		17. INFORMANT <u>Elton Shockley-504 Collins St. Salisbury, Md</u> Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis</u> DUE TO <u>Cardio Vascular Renal</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Insulin Shock - Diabetes</u> DUE TO (c) <u>Insulin Shock - Diabetes</u>							INTERVAL BETWEEN ONSET AND DEATH <u>12 days</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Insulin Shock - Diabetes</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month <u>-</u> Day <u>19</u> Year <u>1957</u> Hour <u>-</u> a. m. <u>-</u> p. m. <u>-</u>				20d. INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) <u>Salisbury</u> (County) <u>Wicomico</u> (State) <u>Md</u>							
21. I certify that I attended the deceased from <u>Nov 8, 1957</u> to <u>Dec 12, 1957</u> that I last saw the deceased alive on <u>Dec 12, 1957</u> , and that death occurred at <u>7:40</u> M, from the causes and on the date stated above							
ACTUAL SIGNATURE <u>G. Herbert Semple</u> M.D.				ADDRESS (Street, city or town, state) <u>Salisbury Md</u> DATE SIGNED <u>12/16/57</u>			
PHYSICIAN'S NAME (Type) <u>G. Herbert Semple</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>12-16-57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>HILLS CHAPEL CEMETERY NEAR SNOW HILL, MD.</u>		22d. LOCATION (City, town, or county) (State) <u>Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>J.E. Stewart Funeral Home, Salisbury, Md</u> ADDRESS <u>Salisbury, Md</u>				24a. REC'D BY REGISTRAR <u>DEC 19 1957</u>		24b. REGISTRAR'S SIGNATURE <u>Mary A. Holloway</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 21 hours after death. Page 1 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 of 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BURMAN V. S.

DEC 19 1957

RECEIVED
FEB 19 1958

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13754 CERTIFICATE OF DEATH

Reg. Dist. No.

13776

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>152 Upton St</u>		d. STREET ADDRESS <u>152 Upton St</u>	
3. NAME OF DECEASED (Type or print) <u>ANNA BEULAH BENTON SMITH</u>		4. DATE OF DEATH <u>December 7 th 19 57</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 4, 1866</u>
9. AGE (In years last birthday) <u>91</u> yrs.		IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired School Teacher</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Railroad Clerk</u>	
11. BIRTHPLACE (State or foreign country) <u>Somerset Co. Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U S A</u>	
13. FATHER'S NAME <u>George Robert Pollitt</u>		14. MOTHER'S MAIDEN NAME <u>Susan Amelia Moore</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO	
17. INFORMANT <u>Mrs. Gordon Bennett (Daughter)</u>		Address <u>152 Upton St. Salisbury, Maryland</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: <u>450.0</u> IMMEDIATE CAUSE (a) <u>Anticoagulant</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u> </u> DUE TO (c) <u> </u>			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>June 19 54</u> to <u>12/7 19 57</u> , that I last saw the deceased alive on <u>12/7/57</u> , 19 <u>57</u> , and that death occurred at <u>11:50 P</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>H. R. Gramse</u>		M.D. <u>Salisbury, Md.</u>	
PHYSICIAN'S NAME (Type) <u>Dr. Fred Gramse</u>		Address <u>S. Division St. Salisbury, Maryland</u> Dec <u>7</u> / 57	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>Dec. 10, 1957</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Parsons Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Salisbury, Maryland</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>HOLLOWAY & COMPANY FUNERAL HOME - SALISBURY, MD.</u>		24a. REC'D BY REGISTRAR <u>DEC 11 1957</u>	
		24b. REGISTRAR'S SIGNATURE <u>Mary H. Holloway</u>	

BOHANN A. S.

TO THE

RECEIVED

13755

CERTIFICATE OF DEATH

1377337

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>Peninsula General Hospital</u>				d. STREET ADDRESS <u>702 Baker St</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Fda Gertrude Smith</u>				4. DATE OF DEATH Month Day Year <u>December 8 1957</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>MAR. 3-</u>	9. AGE (In years last birthday) <u>70</u> yrs	IF UNDER 1 YEAR Months Days Hours Min	IF UNDER 24 HRS Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House work at home - None</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Laurel Delaware</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>Robert Prettyman</u>				14. MOTHER'S MAIDEN NAME <u>MARANDA Ellis</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Mr. Van Smith (Husband)</u> Address <u>702 Baker St. Salisbury Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Status Asthmaticus</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Bronchial Asthma</u> DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH <u>7 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Obesity - Hypertension</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at <u>10:45</u> AM, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE <u>Alberta Mattax</u> M.D.							
PHYSICIAN'S NAME (Type) <u>Alberta Mattax - Camden Ave - Salisbury Md.</u> <u>12/9/57</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>BURIAL</u>		<u>Dec 12 1957</u>		<u>Laurel Hill Cemetery</u>		<u>Laurel Delaware</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Holloway & Co. Funeral Home - Salisbury Md.</u>				ADDRESS <u>Salisbury Md.</u>		24a. REC'D BY REGISTRAR <u>DEC 11</u>	
				24b. REGISTRAR'S SIGNATURE <u>Mary M. Holloway</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

JOHN V. S.

1917

RECEIVED

BUREAU V. B.

REC 22 1957

RECEIVED

1377533✓

13757

CERTIFICATE OF DEATH

Reg. Dist. No.

1 PLACE OF DEATH a. COUNTY Wicomico MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) o STATE Maryland b. COUNTY Queen Anne's			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury				c. LENGTH OF STAY IN It 2 months			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Deer's Head State Hospital				d STREET ADDRESS 17...			
3 NAME OF DECEASED (Type or print) First Walter Middle Summers Last Summers				4. DATE OF DEATH Month December Day 23 Year 1957			
5. SEX Male		6. COLOR OR RACE Colored		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 7/12/1893	
9. AGE (In years last birthday) 64 yrs		IF UNDER 1 YEAR Months 64 Days 0 Hours 0 Min 0		IF UNDER 24 HRS Months 0 Days 0 Hours 0 Min 0			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Oyster Shucker				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Virginia	
12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME Albert Summers				14. MOTHER'S MAIDEN NAME Lucy Watkins			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Unk. (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT Hospital Records	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Ca. of prostate gland with generalized metastases DUE TO metastases Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) metastases DUE TO (c)				INTERVAL BETWEEN ONSET AND DEATH 2 yrs			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour 19 a. m. 19 p. m.				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from October 28 1957 , to Dec. 23 1957 , that I last saw the deceased alive on Dec. 23 1957 , and that death occurred at 8:20 P.M. , from the causes and on the date stated above.							
ADDRESS (Street, city or town, state) Deer's Head State Hospital				DATE SIGNED 12/24/57			
ACTUAL SIGNATURE Dr. V. Juerman				M.D.			
PHYSICIAN'S NAME (Type) V. Juerman, M. D.				Salisbury, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Removal		22b. DATE THEREOF 12-31-57		22c. NAME OF CEMETERY OR CREMATORY Anatomical		22d. LOCATION (City, town, or county) (State) Baltimore, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Boaker McQuest				ADDRESS		24a. REC'D BY REGISTRAR DATE 1/2/58	
						24b. REGISTRAR'S SIGNATURE Mary Holloway	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

ROBERT V. E.

8361 8 Nv.

RECEIVED

13758

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Salisbury Wicomico County		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. LENGTH OF STAY IN 1b 1 yr. 10 mos.		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Kent		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chestertown, Maryland	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Deer's Head State Hospital		e. STREET ADDRESS 227 S. Queen Street				f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Melissa Middle Thomas Last Thomas		4. DATE OF DEATH Month December Day 13 Year 1957		5. SEX Female		6. COLOR OR RACE Colored		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH May 1875		9. AGE (In years last birthday) 82 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) unk		11. BIRTHPLACE (State or foreign country) Chestertown, Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME William Hill		14. MOTHER'S MAIDEN NAME Nancy Hill		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) unk		16. SOCIAL SECURITY NO unk		17. INFORMANT Hospital Records	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Aortic stenosis and insufficiency DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) Hypertensive arteriosclerotic cardiovascular disease DUE TO (c) General arteriosclerosis		INTERVAL BETWEEN ONSET AND DEATH Unk		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) Salisbury, Maryland		(County) (State)	
21. I certify that I attended the deceased from Feb. 9 , 19 56 , to Dec. 13 , 19 57 , that I last saw the deceased alive on Dec. 13 , 19 57 , and that death occurred at 8:50 P. M, from the causes and on the date stated above.									
ACTUAL SIGNATURE <i>Gerhard Kocmehly</i>		M. D.		ADDRESS (Street, city or town, state) Salisbury, Maryland		DATE SIGNED 12/14/57			
PHYSICIAN'S NAME (Type) Gerhard Kocmehly, M.D.									
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12/17/57		22c. NAME OF CEMETERY OR CREMATORY James Cemetery		22d. LOCATION (City, town, or county) Chestertown Maryland		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Margaret Waller</i>		ADDRESS Chestertown, Maryland		24a. REC'D BY REGISTRAR DATE 12/18/57		24b. REGISTRAR'S SIGNATURE <i>Mary Waller</i>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the required information prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

1937

2

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 1813781

13774

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Wicomico MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Dorchester			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sharptown - Rural				c. LENGTH OF STAY IN 1b 3 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Maple Shade Nursing Home				d. STREET ADDRESS Brookview			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Ida Middle May Last Wainwright				4. DATE OF DEATH Month December Day 10 Year 1957			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH December 31, 1875	
9. AGE (In years last birthday) 81 yrs.		IF UNDER 1 YEAR Months 81 Days 0 Hours 0 Min. 0		IF UNDER 24 HRS Months 0 Days 0 Hours 0 Min. 0			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework				10b. KIND OF BUSINESS OR INDUSTRY Home		11. BIRTHPLACE (State or foreign country) Dorchester Co., Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME John Corkran				14. MOTHER'S MAIDEN NAME Elizabeth Rhodes			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO. None		17. INFORMANT G. Garland Wainwright, Rhodesdale, Md., RFD	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) metastatic carcinoma of neck 191X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) DUE TO				INTERVAL BETWEEN ONSET AND DEATH 2			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. p. 19 p. m.				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from Dec 8, 1957 to Dec 10, 1957 , that I last saw the deceased alive on Dec 9, 1957 , and that death occurred at 2300 M., from the causes and on the date stated above.							
ACTUAL SIGNATURE H. S. Kuhlman M.D.				ADDRESS (Street, city or town, state) Sharptown, Maryland DATE SIGNED 12-12-57			
PHYSICIAN'S NAME (Type) H. S. Kuhlman, M.D.				Sharptown, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Dec. 12, 1957		22c. NAME OF CEMETERY OR CREMATORY Brookview Cemetery		22d. LOCATION (City, town, or county) (State) Brookview, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE J. J. Frampton and Son, Federalburg, Maryland				24a. REC'D BY REGISTRAR DEC 16 1957		24b. REGISTRAR'S SIGNATURE Maryl Owens	

U.S. BUREAU

DEC 14

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13759

CERTIFICATE OF DEATH

13782

Reg. Dist. No.

337

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Delaware</u> b. COUNTY <u>Sussex</u> ✓			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Delmar</u> 47			
c. LENGTH OF STAY IN 1b <u>10 DAYS</u>				d. STREET ADDRESS <u>R7D#2</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Peninsula General Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Ruth</u> Middle <u>CATHERINE</u> Last <u>Walter</u>				4. DATE OF DEATH Month <u>December</u> Day <u>22</u> Year <u>1957</u>			
5 SEX <u>Female</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Aug 1, 1914</u>	
9. AGE (In years last birthday) <u>43</u> yrs		IF UNDER 1 YEAR		IF UNDER 24 HRS.		10. MONTHS <u>43</u> DAYS <u>43</u> HOURS <u>43</u> MIN.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life. If not fitted) <u>HOUSEWIFE</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>OWN HOME</u>			
11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>				12. CITIZEN OF WHAT COUNTRY? <u>U. S. B.</u>			
13. FATHER'S NAME <u>GEORGE W. MOSLEE</u>				14. MOTHER'S MAIDEN NAME <u>ESSIE F. HATTON</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NONE</u>				16. SOCIAL SECURITY NO. <u>Wm L. WALTER, SAME</u>			
17. INFORMANT <u>Wm L. WALTER, SAME</u>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Uremia</u> DUE TO (b) <u>Poly cystic Disease</u> DUE TO (c) <u>Subarachnoid Hemorrhage</u>				INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Subarachnoid Hemorrhage</u>				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>Dec 11, 1957</u> to <u>Dec 22, 1957</u> that I last saw the deceased alive on <u>Dec 22, 1957</u> , and that death occurred at <u>4:30 PM</u> , from the causes and on the date stated above.				ADDRESS (Street, city or town, state) <u>224 N. Division St.</u> DATE SIGNED <u>Thomas C. Hall</u>			
ACTUAL SIGNATURE <u>Thomas C. Hall</u> M.D.				PHYSICIAN'S NAME (Type) <u>Salisbury, Md.</u>			
22a. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>12/27/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>HEBRON CEM.</u>		22d. LOCATION (City, town, or county) (State) <u>HEBRON, MARYLAND</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Hill & Johnson Co. Salisbury, MD</u> ADDRESS <u>Norman T. Baker</u>				24a. REC'D BY REGISTRAR <u>REC'D</u>		24b. REGISTRAR'S SIGNATURE <u>Mary Hallaway</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

JEC 20 1957

RECEIVED

13760

CERTIFICATE OF DEATH

13783

Reg. Dist. No.

337

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Somerset			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury, Maryland				c. LENGTH OF STAY IN 1b 7mo. 6 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Deer's Head State Hospital				d. STREET ADDRESS Dames Quarter			
3. NAME OF DECEASED (Type or print) First Emma Middle White Last White				4. DATE OF DEATH Month Dec. Day 8 Year 19 57			
5. SEX Female	6. COLOR OR RACE Colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Mar. 17, 1878	9. AGE (In years last birthday) yrs. 79	IF UNDER 1 YEAR Months 79	IF UNDER 24 HRS Days 79 Hours 79 Min. 79	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) unk		10b. KIND OF BUSINESS OR INDUSTRY unk		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Samuel Holland				14. MOTHER'S MAIDEN NAME Unk			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) unk		16. SOCIAL SECURITY NO unk		17. INFORMANT Hospital Records Address Salisbury, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Ca of rt. lung 160 A DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 160 A DUE TO (c) 160 A							INTERVAL BETWEEN ONSET AND DEATH unk
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)		
21. I certify that I attended the deceased from May 2, 19 57 , to Dec. 8, 19 57 , that I last saw the deceased alive on Dec. 8, 19 57 , and that death occurred at 2:40 A.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Salisbury, Maryland DATE SIGNED 12/8/57							
ACTUAL SIGNATURE L. Maldve		M.D. Salisbury, Maryland					
NAME (Type) L. Maldve, M.D.							
22a. BURIAL, CREMATION, OR REMOVAL (Specify)	22b. DATE THEREOF 12/18/57	22c. NAME OF CEMETERY OR CREMATORY macordonia	22d. LOCATION (City, town, or county) (State) Dames Quarter Maryland				
23. FUNERAL DIRECTOR'S SIGNATURE William H. James Jr. Funeral Home, Inc.		ADDRESS Salisbury, Maryland		24a. REC'D BY REGISTRAR 12/10/57	24b. REGISTRAR'S SIGNATURE Maugh Holloway		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13761

CERTIFICATE OF DEATH

13784

Reg. Dist. No.

332

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE Maryland b. COUNTY Wicomico	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Parsonsborg	
c. LENGTH OF STAY IN 1b 4 days		d. STREET ADDRESS Deer's Head State Hospital	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Deer's Head State Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Minnie Middle F. Last White		4. DATE OF DEATH Month Dec. Day 15 Year 19 57	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6/16/1871
9. AGE (In years last birthday) yrs. 86		10. IF UNDER 1 YEAR: Months 8 Days 6 Hours 15 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) -		10b. KIND OF BUSINESS OR INDUSTRY -	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Joshua Beathard		14. MOTHER'S MAIDEN NAME Martha Adkins	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) Unk.		16. SOCIAL SECURITY NO. -	
17. INFORMANT Mrs. Ida White (Daughter-in-Law) Parsons-		burg, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial insufficiency 4-11-57 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic cardiovascular disease DUE TO (c) Arteriosclerosis, generalized		INTERVAL BETWEEN ONSET AND DEATH 3 days Years Years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Old fracture of left femur		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 11 p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Dec. 11 , 19 57 , to Dec. 15 , 19 57 , that I last saw the deceased alive on Dec. 15 , 19 57 , and that death occurred at 7:40 P.M. , from the causes and on the date stated above. St. Malche ADDRESS (Street, city or town, state) Deer's Head State Hospital DATE SIGNED 12/16/57			
ACTUAL SIGNATURE		M.D. Deer's Head State Hospital	
PHYSICIAN'S NAME (Type) L. V. Maldve, M. D.		Salisbury, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Dec. 18, 1957	22c. NAME OF CEMETERY OR CREMATORY Parsonsborg Cemetery	22d. LOCATION (City, town, or county) (State) Parsonsborg, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE HOLLONAY & COMPANY FUNERAL HOME - SALISBURY, MD.		24a. REC'D BY REGISTRAR DEC 19 1957 24b. REGISTRAR'S SIGNATURE Mary Holloway	

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DEC 10 1957

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 3 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
BM 2/57

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18785
13775 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 13785

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Delaware b. COUNTY Sussex	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. LENGTH OF STAY IN 1b Bethel 46X-5	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Cor. of Locust Ter. & W. Locust St.		d. STREET ADDRESS R.D. #	
3. NAME OF DECEASED (Type or print) First NOLAN Middle BRADFORD Last WILLEY		4. DATE OF DEATH Month December Day 1st Year 19 57	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 2nd, 1941
9. AGE (In years last birthday) 16 yrs.		10. IF UNDER 1 YEAR Months 1 Days 1 Hours 1 Min. 57	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer on Farm		10b. KIND OF BUSINESS OR INDUSTRY Chicken Grower	
11. BIRTHPLACE (State or foreign country) Salisbury, Maryland		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME Bradford M. Willey		14. MOTHER'S MAIDEN NAME Marie O. Niblett	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)	
17. INFORMANT Mrs. Marie Taylor (Mother)		Address Bethel Delaware	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bullet Wound of Head 981X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Golden DUE TO (c) Golden			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Golden			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour 19 a. m. 19 p. m.		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input checked="" type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Earl L. Royer		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) Dr/ Earl L. Royer		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Dec. 5, 1957	
22c. NAME OF CEMETERY OR CREMATORY Parsons Cemetery		22d. LOCATION (City, town, or county) (State) Salisbury, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE HOLLOWAY & COMPANY FUNERAL HOME - SALISBURY, MD.		24a. REC'D BY REGISTRAR DEC 5 1957	
		24b. REGISTRAR'S SIGNATURE Mary Holloway	

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DEC 5 1957

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INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

13776

CERTIFICATE OF DEATH

13786

Reg. Dist. No.

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Wicomico</u>		STATE <u>md</u> COUNTY <u>Wicomico</u>		CITY (If outside corporate limits, write RURAL and give nearest town)		TOWN <u>Delmar</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (If this place)		STREET ADDRESS		(If rural give location)	
TOWN <u>Delmar</u>		<u>yo?</u>		<u>Delmar</u>		<u>md</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Halloway Nursing Home</u>							
3. NAME OF DECEASED (Type or Print) <u>nicodemus Wilson</u>				4. DATE OF DEATH <u>12</u> <u>25</u> <u>1957</u>			
5. SEX <u>m</u>		6. COLOR OR RACE <u>C</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>wid</u>		8. DATE OF BIRTH <u>1867</u>	
9. AGE last birthday <u>90</u> yrs.		IF UNDER 1 YEAR		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>none</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>none</u>		11. BIRTHPLACE (State or foreign country) <u>md</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>?</u>				14. MOTHER'S MAIDEN NAME <u>?</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>?</u> (If Yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT & ADDRESS <u>Lorraine Halloway</u>	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
1420.0 IMMEDIATE CAUSE (A) <u>Artero-sclerotic Heart Disease</u>				INTERVAL BETWEEN ONSET AND DEATH <u>unk.</u>			
ANTECEDENT CAUSE(S) DUE TO (B) <u>Arterio sclerosis</u>				7 years?			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C) <u>Hypertension</u>				<u>unk.</u>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Nephritis</u>				1 year			
19a. DATE OF OPERATION <u>?</u>				19b. MAJOR FINDINGS OF OPERATION <u>?</u>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. PLACE (Home, farm, factory, OF INJURY street, office, bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (M.)				21a. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>Dec 9, 1957</u> to <u>Dec 25, 1957</u> , that I last saw the deceased alive on <u>Dec 25, 1957</u> , and that death occurred at <u>?</u> M., from the causes and on the date stated above.							
SIGNATURE <u>A. Herbert Semblak</u>				ADDRESS (Street, city, town, state) <u>Salisbury Md</u> DATE SIGNED <u>12/28/57</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>12-28-57</u>		NAME OF CEMETERY OR CREMATORY <u>Union Cem</u>		LOCATION (City, town, or county) (State) <u>Delmar md</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <u>Brooks</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Brooks</u>		ADDRESS	
DATE DEC 30 '57							

CERTIFICATE OF DEATH

Name of Deceased		Age		Sex	
William		45		Male	
Residence		Occupation		Cause of Death	
New York		Teacher		Heart Disease	
Date of Death		Place of Death		Physician	
Dec 21 1957		New York		J. H. Smith	
Time of Death		Signature of Physician		Signature of Registrar	
10:30 PM		[Signature]		[Signature]	

BUREAU V. B.

DEC 30 1957

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12-28-57